BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against:	Case No. 12-2011-217415
JAMES E. O'DORISIO, M.D.	OAH No. 2014080414
Physician's and Surgeon's Certificate No. A44147	
Respondent.	

DECISION AFTER SECOND REMAND

Administrative Law Judge Mary-Margaret Anderson, Office of Administrative Hearings, State of California, heard this matter on January 5 through 9, and March 2 through 4, 2015, in Oakland, California.

Jane Zack Simon, Supervising Deputy Attorney General, and Carolyne Evans, Deputy Attorney General, represented Complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

Marvin H. Firestone, M.D., Attorney at Law, and Michael A. Firestone, Attorney at Law, represented Respondent James O'Dorisio, M.D., who was present.

The record remained open to allow the parties to file written closing argument. The briefs were timely filed and marked for identification as follows: Complainant's Closing Argument, Exhibit 20; Respondent's Closing Argument, Exhibit DD; and Complainant's Reply, Exhibit 21.

The record initially closed on May 26, 2015, following receipt of Complainant's reply brief.

The record was reopened on July 8, 2015. A conference call was held with counsel to discuss the possibility that a page of an exhibit may have been missing. Respondent's closing brief referenced page 00060 of Exhibit 6, and it could not be located in the record. Counsel were instructed to meet and confer on the issue of page 00060.

On July 15, 2015, Respondent filed a request that page 00060 and newly found office notes be added to the record. On July 16, 2015, Complainant filed an opposition to the request.

Respondent's request and Complainant's opposition were marked for identification in the record as Exhibit EE and Exhibit 22, respectively.

The record closed on July 16, 2015.

On July 28, 2015, the administrative law judge submitted her proposed decision to the Medical Board of California. The board adopted that decision on August 24, 2015, to become effective on September 23, 2015.

Thereafter, respondent filed a Petition for Reconsideration and for Stay. On September 15, 2015, the board granted the stay until October 23, 2015 for the sole purpose of allowing Respondent to file a Petition for Reconsideration. After Respondent filed his Petition for Reconsideration, the board issued an order extending the stay for the purpose of allowing the Board time to review the Petition for Reconsideration. Following its review, on October 29, 2015, the Board issued its Order Denying Petition For Reconsideration effective November 2, 2015.

Respondent subsequently petitioned the Superior Court for a Writ of Administrative Mandamus. On May 6, 2016, the court issued its order granting in part and denying in part the writ petition. The court issued its Judgment on May 25, 2016 remanding the matter to the Board for assessment of the penalty on the basis of the findings and determinations set forth in its Order.

Having reconsidered its Decision pursuant to the court's direction in the Judgment and Order, and after affording the parties the opportunity to make oral and written arguments, the board now makes a modified decision in compliance with the Judgment.

On April 14, 2017, the Superior Court of the County of San Francisco granted Respondent's Petition for Writ of Administrative Mandate and instructed the Board that it had abused its discretion when it increased the probation monitor term in its decision of December 2016. Accordingly, the Superior Court instructed the Board that it could not fix a penalty greater than the one established in its August 2015 decision and remanded the matter back to the Board to establish the appropriate level of discipline.

On June 26, 2017, the Board issued a Notice of Hearing for Oral Argument and set the time and date for oral argument on July 26, 2017 in South San Francisco. On that date, Respondent and his counsel did not appear due to a possible scheduling or calendaring error but having determined that notice of the hearing was properly served, the matter proceeded and the Office of the Attorney General (AGO) was present. The AGO objected to the documents attached to Respondent's written argument, and the Board did not consider the attachments in making its decision on this matter.

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EVIDENTIARY RULINGS

RB's operative report, page one-page 00060

1. Exhibit 6 contains portions of patient RB's medical records. Bates-stamped page 00060 is a page from her certified medical records that was included in discovery, but was not originally made a part of Exhibit 6. Respondent, however, referenced page 00060 in his closing brief. The record was reopened and the parties asked to respond to these facts.

2. Page 00060 is the first of two pages of Respondent's operative report following his performance on January 31, 2011, of a right carotid endarterectomy on RB. Respondent requests that page 00060 be included in the administrative record as part of Exhibit 6.

Respondent also requests that uncertified records, described as "Office Notes from 1/28/10, 7/29/10, and 8/26/10" be added to the record. These documents were not provided to Complainant in discovery, are not authenticated, and are reported to have been recently found.

Complainant objects to the admission of any of the documents.

3. Respondent's request is granted as to the admission of page 00060 as part of Exhibit 6. The merits of a complete administrative record outweigh Complainant's concerns that the late admission prevents specific comment by Complainant's expert and cross-examination of Respondent regarding the document. There is no need for expert analysis of page 00060.

4. Respondent's request is denied as to the admission of the "Office Notes." Good cause does not exist to augment the record with these new documents. To do so without prejudice to Complainant would require re-convening the administrative hearing. Considering all of the relevant facts and argument, it is concluded that the probative value of the additional evidence is substantially outweighed by the undue consumption of time that would be necessary. (Gov. Code, § 11513, subd. (f).)

Admission of Exhibit 19

5. At the last hearing session, Complainant offered a declaration from Kira Parisi (marked as Exhibit 19) as rebuttal evidence. Respondent objected, and a ruling was deferred pending the receipt of argument in the closing briefs.

6. Exhibit 19 was offered to rebut Respondent's testimony that he reviewed imaging studies as to patient SD. It is a declaration from an employee of a radiology laboratory, who asserts that she is "familiar with the record keeping system . . . and if called as a witness, could competently testify" to such matters. She declared that, among other things, she searched the laboratory's records and did not find a request for study images for RB from Respondent or anyone else.

7. Exhibit 19 is a hearsay declaration offered for its truth. Government Code section 11513, subdivision (d), provides that hearsay is admissible to supplement or explain other

evidence, but if objected to, is insufficient to support a factual finding unless a hearsay exception applies. Respondent objected to Exhibit 19.

8. Complainant asserts Exhibit 19 qualifies for an exception under Evidence Code section 1272 as evidence of the absence of a business record. It was not established that Exhibit 19 qualifies for admission under Evidence Code section 1272. (See *People v. Dickinson* (1976) 59 Cal.App.3d 314, 318.) It does not meet the criteria for any hearsay exception, and is therefore not admitted as direct evidence.

9. Exhibit 19 is admitted as administrative hearsay. (Gov. Code, § 11513, subd. (d).)

FACTUAL FINDINGS

1. Complainant Kimberly Kirchmeyer issued the Accusation in her official capacity as Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On October 26, 1987, the Board issued Physician's and Surgeon's Certificate No. A44147 to James E. O'Dorisio, M.D. (Respondent). As of November 14, 2014, it was scheduled to expire on April 30, 2015, unless renewed. Respondent is a vascular surgeon.

3. The Accusation alleges that Respondent committed unprofessional conduct (gross negligence, negligence, incompetence, and/or failed to maintain adequate and accurate medical records) in the treatment of five patients. As to two patients, he was alleged to have made false and misleading statements in the medical record. Respondent filed a notice of defense and this hearing followed.

4. The standard of proof applied in making the factual findings is clear and convincing evidence to a reasonable certainty.

Respondent's background

5. Respondent received a bachelor's of science degree from the University of Denver with a double major in chemistry and biology in 1978 and graduated from the University of Colorado Medical School in 1982. While at Colorado, he was influenced by Robert B. Rutherford, M.D., Chief of Vascular Surgery and author of Vascular Surgery, the preeminent textbook. He chose residency programs in accordance with his early interest in vascular surgery: Baylor College of Medicine and Cornell University Medical College. At Baylor, Michael DeBakey, M.D., considered the father of cardiovascular surgery and the inventor of the carotid endarterectomy surgical procedure, was head of the program. Respondent was Dr. DeBakey's personal resident twice.

In 1989, Respondent completed a residency in cardiothoracic surgery at the University of California, San Francisco, Medical School (UCSF). He then moved to Michigan, where he was

in private practice until 2005. In the meantime, in 2000, he returned to California for a fellowship in endovascular surgery at Stanford.

In 2005, Respondent moved to California and worked in the Kaiser Permanente system for one year. From 2007 until 2014, he was in private practice with Northern California Medical Associates, Inc., in Santa Rosa. He left the group in May 2014.

6. Respondent estimates that he has performed nearly 10,000 surgical procedures in his career, including at least 1,000 carotid endarterectomy (CEA) surgical procedures. Since moving to California, he believes he has performed over 200 CEA's. One of these patients died, one died following a "re-do," and one patient had a stroke. Respondent testified that he has never been sued for malpractice, but in his Board interview said there was a lawsuit in Michigan in approximately 2002 that was settled for $75,000.

7. Respondent is not board certified. On one occasion he did not pass the written general surgery exam, but subsequent exams were not taken because of family obligations. Respondent is, however, highly trained as a cardiac and vascular surgeon, and has over 25 years of experience.

8. Respondent has had special training in reading carotid ultrasound images. In the mid-1990's he obtained national certification for a laboratory in his community in Michigan. He was medical director of the laboratory, read results there, and continued to do so for non-invasive studies after moving to California.

9. In 2008, Respondent's son, age 16, was diagnosed with a rare form of cancer that had already metastasized. During his initial treatments, Respondent did not change his practice despite supervising his son's care and spending a great deal of time with him. There was some improvement, but he experienced a recurrence in 2010. At that point Respondent changed his schedule to accommodate assisting his son with treatments, including by traveling with him to other cities, sometimes out of state. Respondent reduced his practice of medicine after that date. He also formed a company to conduct research on new treatments for cancer.

10. Respondent's care of the five patients that are the subjects of this case occurred at Sutter Hospital in Santa Rosa. In 2011, concerns were raised by the quality department about complications in CEA's performed by Respondent. Reviews of the cases were undertaken, and restrictions imposed including that Respondent consult with a neurologist before proceeding with surgery. Subsequently, the Medical Executive Committee voted to revoke his hospital privileges. Respondent appealed. Following presentations by both sides, a settlement was offered through a mediation process, and Respondent accepted it. As part of the settlement, Respondent relinquished his privileges at Sutter Santa Rosa.

11. Respondent has hospital privileges at Ukiah Valley Medical Center, with no restrictions. As of the date he testified, he was keeping close control on his hours, to be available for his son.[1] He was working approximately nine to five, unusual for a surgeon, and performing

[1] Respondent's son passed away on May 15, 2015

every procedure except cardiac surgery. Respondent was also working at the hospital's wound center, and was set to become the director the following month.

Expert opinion evidence

12. Including Respondent, six physicians, all experts in vascular surgery, opined regarding the standard of care for the performance of CEA procedures and Respondent's care of the five patients. Two of the experts authored written reports.

EUGENE LEE, M.D.

13. Eugene Lee, M.D., is a California licensed physician and surgeon, and is board certified in vascular surgery. He received his medical degree from Tufts University in 1994, and completed a general surgery residency at the University of Minnesota in 2002 and a fellowship in vascular surgery at Stanford Medical School in 2004. Dr. Lee is the Chief of Vascular and Endovascular Surgery at the Sacramento Veterans Affairs Medical Center, and he performs CEA's at that facility two to three times weekly. He is also an Associate Professor in the Department of Surgery at the University of California at Davis Medical Center. Dr. Lee is an active member of the Society of Vascular Surgery and many other professional organizations. He is extensively published in peer-reviewed journals, and has authored two book chapters. Dr. Lee testified at hearing and also authored a written report.

DANIEL NATHANSON, M.D.

14. Daniel Nathanson, M.D., is a California licensed physician and surgeon, and is board certified in vascular surgery. He received his medical degree from Pennsylvania State University College of Medicine in 1997, and completed general surgical residencies at both St. Vincent's Hospital and Medical Center in New York (2000) and Brigham and Women's Hospital in Boston (2004). Dr. Nathanson completed a fellowship in vascular surgery at UCSF in 2007. He is the Director of the Endovascular Surgery Program at California Pacific Medical Center. He is also a Clinical Associate Professor at UCSF, where he teaches vascular surgery to general surgery residents.

LEWIS SCHWARTZ, M.D.

15. Lewis Schwartz, M.D., is licensed as a physician in Illinois, Michigan, Massachusetts, and North Carolina, and is board certified in general surgery and vascular surgery. He was licensed in California at one time, but has not practiced here. He received his medical degree from the University of Chicago Pritzker Medical School in 1987. He completed a surgical residency at Duke University Medical Center in 1994, and a fellowship in vascular surgery at Brigham and Women's Hospital in Boston in 1995. He has taught surgery at the University of Chicago in one position or another since approximately 2002. His current title is Clinical Associate Professor. He currently performs surgery one week each month. Dr. Schwartz is a distinguished fellow of the Society of Vascular Surgery and is on the editorial board of the Journal of Vascular Surgery. He is extensively published.

Dr. Schwartz met Respondent approximately 20 years ago when Respondent was practicing cardiac and vascular surgery in Michigan. In addition to reviewing the patient records, expert reports and other documents in evidence, he discussed the case with Respondent and was present for most of the hearing. He testified and authored a written report. Dr. Schwartz is of the opinion that Respondent is a talented surgeon.

PERRY M. SHOOR, M.D.

16. Perry M. Shoor, M.D., is a California licensed physician and surgeon and is board certified in vascular surgery. He received his medical degree from The Chicago Medical School (now the University of Health Sciences) in 1971. He completed a surgical residency followed by a fellowship at University of California, San Diego, in 1978. Dr. Shoor completed a fellowship in peripheral vascular surgery at Stanford in 1979. He practiced as a vascular surgeon from 1979 until 2010, when a hand injury ended his surgical practice. Dr. Shoor estimates he has performed between 1,100 and 1,200 CEA's in his career. He is a member of the Society of Vascular Surgery, and is a published author of articles and book chapters.

ROSS MILNER, M.D.

17. Ross Milner, M.D., is licensed as a physician in Illinois. He received his medical degree from the University of Pennsylvania in 1994, and completed a surgical residency and a fellowship in vascular and endovascular surgery at the same institution. Dr. Milner was the program director for the vascular surgery fellowship program at Emory University for seven years, then became chief of vascular surgery at Loyola University Medical Center in Chicago. Currently, he is a full professor at the University of Chicago Medical Center, where he also practices surgery between 60 and 70 hours per week. Dr. Milner is extensively published, with approximately 80 peer-reviewed articlés and over 20 textbook chapters. He estimates he has performed over 500 CEA's in his career, with the most recent occurring in February 2015.

ADDITIONAL EXPERT EVIDENCE

18. In addition to the expert testimonial evidence, the factual findings are informed by *Rutherford's Vascular Surgery,* seventh edition, chapter 95, "Carotid Artery Disease: Endarterectomy" (Rutherford's). It was undisputed that Rutherford's is the authoritative textbook in the specialty. In addition, information from peer-reviewed journal articles in evidence, as explained or referenced by the expert witnesses, also informed certain factual findings. These include guidelines issued by the Society for Vascular Surgery issued in 2008 (SVS Guidelines).

Analysis of expert opinions

19. Although the experts' opinions varied as to the standard of care to some extent, they did not differ in many respects. All of the experts offered valuable information and rendered opinions that were persuasive to various degrees. As no expert was entirely persuasive or not persuasive, a general finding to that effect is not made. Each expert's opinion was carefully considered in making each finding, whether or not the particular expert's opinion is

reported in the factual finding.

Overview of procedures to treat blockages of the carotid artery

20. Vascular surgeons treat carotid artery disease. The carotid artery is located in the neck, between the ear and lower neck. It provides oxygenated blood from the heart to the brain. There are three main segments of the carotid artery: the common carotid artery (CCA), the internal carotid artery (ICA), and the external carotid artery (ECA). The carotid bulb is the point where the CCA bifurcates into two branches and becomes wider.

21. This matter primarily involves Respondent's performance of CEA's, which treat stenosis (narrowing or constricting of the diameter) of the carotid artery. Cholesterol plaque (also called atherosclerosis or blockage) can form in the carotid artery and the resulting stenosis can inhibit or block blood flow. The plaque itself, or blood clots attached to it, can break off and travel to the brain through the ICA, and cause a stroke.

22. There are two surgical approaches used to treat patients with stenosis. One is carotid stenting. A balloon is inflated within the artery, expanding a stent, which compacts the plaque against the wall of the artery, preventing it from breaking off. The other is the CEA.

23. To perform a standard CEA, the surgeon opens the carotid artery and removes plaque, generally following a longitudinal incision. Opening the artery cross-wise is called the eversion technique. Whichever method is used, the artery is closed with sutures in the arterial wall or with a patch.

24. CEA's are dangerous surgeries. The risks include bleeding, stroke and death. They should only be performed for patients with high levels of stenosis and where it is clear that the risk of stroke will be reduced; in other words, when the potential benefit outweighs the risk of surgery.

25. Different types of imaging studies may be conducted to show the degree of stenosis, and each have risks, benefits, and costs. They also report the degree of stenosis in different ways. The carotid duplex ultrasound (CDUS) is considered accurate and reliable, and is non-invasive. It is a duplex study because it reports both a picture of the artery, which can reveal the character of the plaque, and the degree of velocity, which gauges the amount of stenosis by how fast the blood is flowing through the artery. An instrument uses ultrahigh-frequency sound waves to penetrate the skin, and applies the Doppler principle to estimate the velocity of blood flowing through the artery. The higher the velocity is, the higher the degree of stenosis. The velocity is reported, and a color-coded two-dimensional image of the artery is provided, which shows the shape and size of the plaque. The colors represent blood flow direction. The estimate of the amount of stenosis is given in a range, such as 60 to 70%. In most cases, a CDUS is the only imaging study needed to evaluate a patient for a CEA.

The magnetic resonance angiogram (MRA), a study using magnetic resonance imaging, is also noninvasive, but may overestimate the degree of stenosis. An MRA gauges the size of the plaque and the lumen (the cavity of the vessel) by how fast protons are spinning inside the cells.

Other types of studies are quite invasive. A computed tomographic angiogram (CTA), also called a CAT scan with angiography, is more expensive, and requires the infusion of a chemical dye. And a conventional angiogram requires puncturing a femoral artery in the groin to thread a catheter to the base of the neck. Contrast dye is injected into selected arteries and x-rays show the location and extent of blockage.

26. Radiologists interpret imaging studies and issue written reports of their findings. Other medical specialists can also interpret imaging studies, depending upon their training and experience. Vascular surgeons generally are so trained, and can have valid opinions that can differ from the radiologist's interpretation.

27. A completion study is a test performed after the CEA procedure is completed. It is an objective test and can consist of any of the studies discussed above, performed in the operating room, or later when and if the patient exhibits neurological defects. A continuous wave Doppler (CWD) can be used as a completion study, but it does not result in an image that can be studied.

Indications for CEA for asymptomatic patients

28. The goal of a CEA is to reduce the risk of stroke. The main risk factors for strokes caused by carotid atherosclerotic disease are the presence of related symptoms and the degree of carotid stenosis. Studies have been conducted and guidelines issued by professional societies to help determine what degree of stenosis warrants the risk of a CEA procedure. The degree is very important in making that decision, but the relevance of the degree varies depending upon other factors, including whether the patient has symptoms that are signs of carotid artery disease; in other words, whether the patient is symptomatic or asymptomatic. It is a somewhat controversial and evolving area of study as to what degree of stenosis warrants the invasive procedure of a CEA, and what does not, particularly in an asymptomatic patient.

29. As regards symptomatic patients, the consensus is that a CEA is beneficial where the stenosis is severe. For asymptomatic patients, the benefits of CEA are less clear and the degree of stenosis that establishes benefit is not as well established. Nonetheless, Rutherford's and the SVS Guidelines are consistent. They assert that significant benefit has been established for asymptomatic patients with stenosis equal to or greater than 60%. Each of the retained experts in this matter agreed, although Dr. Nathanson identified it somewhat differently as 60 to 70%. And in his interview, Respondent identified the degree of stenosis as 70% or greater, but added that "there are certainly very large studies that use 60% asymptomatic as their cutoff."

Dr. Lee, however, introduced a qualifier to the guidelines because of his understanding that the studies underlying the conclusion used angiographic results to report the degree of stenosis. He asserts that an angiogram result of 60% correlates with 80% in a CDUS, and that therefore a CDUS of equal to or greater than 80% is needed before a CEA can be recommended for an asymptomatic patient. He was adamant on this point, stating that it is well understood by vascular surgeons, and that there is no confusion regarding this matter. Dr. Lee's references to the literature to reinforce his opinion, however, were not successful, and Dr. Schwartz was

equally adamant that it was incorrect. Dr. Schwartz opined that there is no expectation that an ultrasound that reads 80% is actually 60%; that the expectation is that the correlation is one-to-one. Dr. Lee was not persuasive on this point.

30. According to Rutherford's and other sources, there is no consensus on which imaging modality is the most accurate for determining the degree of stenosis. There are studies that report some evidence for better accuracy from each of the CDUS, MRA, and the CTA modalities. There is evidence that the MRA overestimates degree, which makes it harder to differentiate more moderate from severe stenosis. On the other hand, as stated above, the CDUS is now the most commonly used imaging study when evaluating a patient for a CEA, and procedures are commonly done following the CDUS alone.

31. There are instances, however, when one study is insufficient. On the subject of when there is a need for additional imaging testing, Rutherford's concludes:

> Clearly, if the patient is found to have an intermediate stenosis and is asymptomatic, one should perform at least another noninvasive test to confirm this finding before recommending CEA. If there is discordance between these studies, one should either obtain a third non-invasive test or resort to angiography. . . .

The SVS Guidelines concur. Specifically as to the CDUS, they recommend additional imaging studies before surgical intervention where the degree is reported in the intermediate range of 50% to 69%.

32. Regardless of the imaging study used and the degree of stenosis reported, the decision to perform a CEA is made based upon all of the available data. This includes information specific to the individual patient, such as is gleaned by history and physical examination and other tests, other conditions the patient may have, the patient's personal preferences, and the surgeon's judgment based on training and experience. In other words, the decision is not properly made based upon the results of an imaging study standing alone.

Patient SB

33. Patient SB,[2] an 80-year-old male, first presented to Respondent on March 4, 2010, for a consultation. He had a previous history of stoke and left CEA eight years prior. SB did not report any transient ischemic attacks (TIA), syncope (fainting), or new weaknesses. SB had residual weakness in his right arm, but otherwise functioned well.

34. A CDUS on February 11, 2010, revealed 50% to 69% stenosis of the right internal carotid artery and 80% to 90% restenosis of the left internal carotid artery, with peak velocities over 600 cm/sec. Respondent noted[3] that he discussed the option of carotid stenting with SB, but that SB wanted to have a second CEA. Respondent did not obtain any additional imaging

[2] Patients are referred to by numbers to protect privacy.

[3] "Noted" means Respondent entered the information in a patient's medical record.

studies.

35. On March 19, 2010, Respondent performed a "re-do" left CEA on SB. He noted that it was a long and difficult operation. Instead of plaque, which can be removed, Respondent found neointimal hyperplasia, which cannot. A classic CEA was therefore not performed; instead, Respondent widened the artery, using a patch angioplasty.

36. There is no indication in SB's medical record that an assistant was present for the surgery.

37. Respondent did not obtain a completion study following the procedure.

38. At 10:30 p.m., Respondent made the first post-operative note, containing status information such as that the procedure was a left CEA re-do with a Dacron patch repair with no complications. He also noted that SB's right arm is slightly weaker than his left from an old stroke, and that "this is his base line." At 11:30 p.m., approximately one hour after the surgery, Respondent noted that SB: was slow to wake in the recovery room; had occasional left arm and leg movement but the right side was quiet; that he was not yet responding to verbal commands; and that he had an interrupted breathing pattern. The experts agree that these observations were consistent with a stroke. Respondent testified that he consulted with a neurologist and intensivist (the physician assigned to the intensive care unit, or ICU) in the early morning hours, and it was decided that SB would remain in the ICU and receive intravenous heparin (a blood thinner) with the hope of dissolving the clot that was blocking the flow to the brain and preventing further clot formation. Respondent, however, did not document a treatment plan, and made no further chart notes until the following day.

39. Another physician ordered a CT imaging study at approximately 4:35 a.m. the next morning, which showed an occluded left carotid artery.

40. A CDUS taken March 20, 2010, showed complete occlusion of the left common and internal carotid arteries. A CT scan of SB's head on March 21, 2010 showed a massive stroke. SB died on March 23, 2010.

41. Respondent's operative report states that it was dictated on April 7, 2010.

42. Complainant alleges that Respondent's care of SB constituted gross negligence, negligence and/or incompetence and the failure to maintain adequate and accurate records in the following five respects.

ALLEGATION 1:
Preoperatively, Respondent did not obtain appropriate imaging studies, such as a CT angiogram.

43. Dr. Lee opined that Respondent's failure to obtain another imaging study, specifically a neck and chest CT angiography, prior to performing the CEA was below the standard of care. That test would have revealed the extent of internal carotid artery disease and

arch anatomy, which informs the decision of which procedure, if any, should be performed. As the lesion was on the neck, in this instance the test would not have contributed very much relevant information, but should have been performed. Dr. Nathanson concurred with this opinion, reasoning that a CTA helps to show the location of the disease, and helps in the decision of whether the patient is a candidate for a stent. He cannot "think of anytime I did a re-do without additional imaging studies." In addition, he believes that such studies assist when discussing the options with the patient.

44. Respondent, and Drs. Schwartz, Milner and Shoor, disagree. They concur that the CDUS provides sufficient information to proceed with a CEA, even a re-do. An angiogram would be indicated if a stent was planned, but was not necessary in this case. It was clear that there was a very high degree of stenosis and that SB preferred a CEA over other procedures. Patient SB had been referred from another physician, who had done a thorough work-up.

45. The CDUS result was 80 to 90% restenosis in the left carotid; it was not disputed that a CEA was warranted. As regards additional imaging studies, the literature recommends such be done where the result shows moderate stenosis, not severe. It is concluded that obtaining an additional imaging study prior to the CEA was at the surgeon's discretion.

46. It was not proven to the required standard that the failure to obtain additional imaging studies prior to performing a CEA in the case of SB was below the standard of care.

ALLEGATION 2:
Respondent did not provide proper counseling to SB prior to surgery.

47. Dr. Lee opined that the lack of a second pre-surgical imaging study meant that SB did not have sufficient counseling prior to surgery.

48. Respondent's notes dated March 4, 2010 state: "Option of current stenting discussed with the patient and he has no interest in carotid stenting and would like to proceed with carotid surgery. All risks and benefits were discussed. Will plan for this." Respondent testified that he discussed the surgical options and the risks and benefits of a re-do CEA, as well as stenting, with SB. Respondent could have performed either procedure. SB, however, was strongly opposed to stenting, because of stories from friends and family members who had bad outcomes.

49. It was not proven that Respondent's pre-surgical counseling of SB was below the standard of care.

ALLEGATION 3:
Intraoperatively, Respondent failed to obtain and/or document a completion imaging study in the operating room at the conclusion of the operation.

50. Dr. Lee asserted that an imaging study should have been obtained given the difficulty of the procedure, and SB's history and condition. Drs. Lee and Nathanson opined that Respondent's failure was a departure from the standard of care.

51. Respondent explained that he always uses continuous wave Doppler, which is a type of completion study. He uses the Doppler in conjunction with a "look, listen and feel" method to assess the patient's condition. There is no image to look at, but his trained ear recognizes the appropriate sounds and can assess the patient.

52. It is recognized that a continuous wave Doppler is a type of completion study, but it is not an imaging study. SB's surgery, the second attempt to clear stenosis, was described by Respondent as one of his most difficult in five years. Although the decision to proceed with surgery was supportable, the risk of stroke was great. Technical problems with the procedure can increase the risk of stroke. It was incumbent upon Respondent to obtain the information revealed by an imaging study before concluding the procedure.

53. It was proven that Respondent's failure to obtain and document a completion imaging study of SB was below the standard of care.

ALLEGATION 4:
Post-operatively, when it was observed that SB had neurologic deficits, Respondent failed to properly evaluate, diagnose, or exclude a technical problem. The standard of care is to manage the problem immediately, with either urgent carotid duplex study or re-exploration of the carotid artery. Neither was done.

54. A post-operative stroke is almost always caused by a technical error during surgery. An imaging study post-procedure might have identified issues that needed correction, but none was done immediately, or even after SB evidenced neurological problems at 11:30 p.m. Once the deficit was noticed, Respondent might have returned SB to the operating room, re-sectioned the segment of diseased artery and placed a graft. Dr. Lee opined that SB should have been evaluated prior to leaving the operating room, and certainly immediately following the observation of neurological deficits at approximately 11:30 p.m.

55. There is scant evidence in the medical record of Respondent's attention to SB post-operatively. Respondent does not recall if he remained at the hospital. He testified that he remained involved and "would have" discussed the case with the intensivist. In sum, Respondent asserts that he and the intensivist discussed the case, he decided not to go back to the operating room, and decided that SB would remain in the recovery room and receive heparin. None of this is documented, except the fact that heparin was given. The records show that another physician ordered a CDUS at 4:30 a.m. the following morning, five hours after the deficits were observed.

56. Respondent's position that his care met the standard is belied by a statement in his interview. He said that he "would typically order the two tests that were ordered to try to help me make that decision. That is a carotid ultrasound and CT scan." In fact, it appears that the experts agreed that Respondent did not have sufficient information to determine that it was futile to return SB to the operating room at the time he asserts that he made that decision.

57. Dr. Schwartz's opinion that the post-operative treatment of SB was within the standard of care was based upon studies showing a lack of benefit from re-exploration following observation of a new deficit. He appears to miss the point. The issue is Respondent's post-operative management of the patient, including during the time period before the stroke was confirmed. And Respondent's argument that the record supports a conclusion that the stroke occurred perioperatively is not supported by the evidence.

58. Dr. Nathanson succinctly described the standard of care when he described what he would have done if SB was his patient: that he would sit bedside and establish whether or not a neurologic event had occurred, obtain an emergent CDUS, and either take the patient back to the operating room, or decide not to do so.

59. The evidence established that Respondent's post-operative care of SB constituted an extreme departure from the standard of care and gross negligence.

ALLEGATION 5:
Respondent's failure to dictate his operative report in a timely manner, his failure to document the presence of an assistant during the procedure, his failure to document a completion study (if one was done), and his failure to document a treatment plan when neurological deficits were observed constitutes unprofessional conduct and the failure to maintain adequate and accurate medical records.

60. The standard of practice requires physicians to make and maintain accurate and sufficient medical records for their patients. A 20-day delay in dictating or writing an operative report violates this standard. Timeliness, which generally assists in accuracy, is particularly important in the case of a patient who has undergone a complex and difficult surgical procedure, and who will then be followed by other health care professionals in the crucial time immediately following the surgery. Respondent argues that dictation of reports sometimes does not get transcribed, and that he has had to re-dictate reports in the past, although there is no evidence that this occurred in SB's case. He also argues that when something is always done, for example, having an assistant for the procedure, it is not necessary to be documented. This assertion is not accepted.

In the report he eventually prepared, Respondent failed to document the completion studies he asserts he performed, and the treatment plan he decided upon with the intensivist. He failed to mention that he had an assistant, and who the assistant was. (It is noted that in the case of patients RB and SD, the same operative report format was used by Respondent, and there is a category identified as "ASSISTANT" followed by the name of a physician.) His notes immediately following the surgery were cursory.

61. It was established that Respondent failed to maintain adequate and accurate records for SB.

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Patient RB

62. Patient RB, then a 66-year-old woman, saw Respondent for a consultation in 2010. She had a prior history of stroke. On August 13, 2010, Respondent performed a left CEA. On October 5, 2010, he performed an abdominal aortic and bilateral iliac balloon angioplasty. RB was a continuing patient of Respondent's and he asserts he knew her well.

63. On December 16, 2010, RB saw Respondent for a follow-up examination and a CDUS taken December 10 was discussed. The report showed 70 to 80% stenosis in RB's right internal carotid artery. Respondent wrote RB's physician that the report showed "progressive stenosis of the right side, now approaching 80%." She was asymptomatic. He recommended a right CEA and RB agreed.

64. Respondent performed a right CEA on January 31 through February 1, 2011. In one operative report, in the Indication section, Respondent wrote that RB had multiple cardiovascular problems, including bilateral carotid disease. She has had a previous stroke that involved weakness of her left arm and leg. Symptoms mostly had resolved over the years. She more recently had a left carotid endarterectomy for severe internal carotid artery stenosis and *now is brought in for elective right carotid endarterectomy for a greater than 80% right internal carotid artery stenosis.* [Emphasis added.]

65. The procedure went well, but post-operatively RB evidenced a neurologic deficit. A CDUS was obtained that showed compromised flow. Respondent undertook a re-exploration that was very difficult. He found RB's artery to be "friable," which means very fragile, thin, and/or falling apart. He used a saphenous vein from her left ankle to replace a segment of the artery and inserted a self-expanding stent.

Respondent did not obtain a completion study after the procedure.

In another operative report in the Indications section, Respondent wrote that RB had experienced a good postoperative result from the left CEA, and that "She also now has a progressing, now about 80%, right carotid stenosis."

66. On February 2, 2011, RB died following a stroke. In a death summary, Respondent wrote that RB had "progressive stenosis now of the right side . . . ."

67. Complainant alleges that Respondent's care of RB constituted gross negligence, negligence and/or incompetence and the failure to maintain adequate and accurate records in the following three respects.

ALLEGATION 1:
Respondent inaccurately and inconsistently reported patient RB's carotid duplex results, including the degree of stenosis.

68. The consult letter Respondent wrote on December 16, 2010, states: "Her follow-up carotid ultrasound . . . also shows, though, progressive stenosis of the right side, now

approaching 80%. [RB] is asymptomatic but because of her progressive stenosis on the right side we have discussed elective right carotid endarterectomy . . . ."[4] In one operative report, Respondent wrote that RB had "a greater than 80% right . . . stenosis," and in another that she had "a progressing, now about 80%, right carotid stenosis." The death report states that "she had progressive stenosis now of the right side." In his report to the Sutter Medical Executive Committee, Respondent wrote that RB had a right CEA "for an 80% stenosis."

69. As stated in Finding 63, the CDUS reported stenosis of 70 to 80%. To report the stenosis as greater than 80% was therefore inaccurate. The degree of stenosis is a very important factor in determining whether to proceed to surgery, particularly where, as here, a patient is asymptomatic. If his opinion of the degree differed from the radiologist's, he should have written the opinion in the record. Respondent argues that at least in the operative report, his description of the degree of stenosis likely came from his own observations during surgery. But this argument is belied by his statement in his interview, when he said that he could "get a feeling of how much . . . plaque is there. But because you have disrupted it . . . I could not look down the barrel and say . . . it was 80%, because it could look 90% now or . . . 70% now."

70. It was established that Respondent's report of RB's CDUS results was inaccurate, and that this violated the standard of care.

ALLEGATION 2:
Respondent inaccurately reported that RB's carotid duplex showed progressive stenosis of the right carotid artery.

71. Respondent reports four times in the medical record that RB's stenosis in her right carotid was "progressive," but no other evidence supports these statements. Respondent asserts that he based the characterization on his initial performance of a left CEA, and by following her over the subsequent year. Respondent followed up with examinations concerning all of RB's vascular issues, one of which was carotid artery disease. He believed that she had progressive disease in that she had known carotid stenosis and the most recent CDUS had shown narrowing that caused a recommendation for surgery. The left was at less than 40% after surgery, but the right was 70 to 80%, which showed significant disease, sufficient so that she was a candidate for a right CEA. Further, Respondent's consult letter implies that his conclusion that the stenosis increased in the four months between the studies is supported by a comparison of older and newer studies. But there is no older study in the medical record. Dr. Lee's opinion that Respondent's description of the stenosis as progressive was inaccurate and below the standard of care was persuasive.

72. It was established that Respondent's report that RB's CDUS showed "progressive" stenosis was inaccurate, and that this violated the standard of care.

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[4] Respondent's closing brief quotes the letter as follows: "patient is asymptomatic, however, due to the progressive stenosis on the right side, a right CEA was recommended." This quote is inaccurate.

ALLEGATION 3:
Post-operatively, Respondent failed to obtain a completion imaging study in the operating room at the conclusion of the second operation, which is an extreme departure from the standard of care.

73. RB initially did well following the right CEA on January 31, 2011, but as first described above, she was returned to the operating room when she exhibited a neurologic deficit. Immediately prior to and during the second operation, Respondent employed imaging studies and monitoring to assist him that included a CT scan of RB's brain, cerebral monitoring and a series of intraoperative arteriograms. Respondent also utilized his usual method of continuous wave Doppler, and "look, listen and feel." He did not obtain a completion imaging study at the conclusion of the operation.

74. Drs. Lee and Nathanson again opined that a completion imaging study should have been obtained. They described the intra-operative studies as insufficient to satisfy this requirement. This was not a routine procedure. Respondent performed an end-to-end anastomosis on the artery with a vein graft. An arteriogram revealed a size mismatch between the artery and the vein at the transition point. Given the level of difficulty, the possibility of difficulty with blood flow through the vessel was greater. After the stent was deployed and flow reestablished, a post-intervention angiogram that included all portions of the artery should have been done. Drs. Lee and Nathanson were persuasive that this was an extreme departure.

75. It was established that the failure to do a post-procedure, completion imaging study was an extreme departure from the standard of care and gross negligence.

Patient DC

76. Respondent first saw female patient DC, then 71 years old, on August 18, 2010. She reported having two episodes of slurred speech within a three-week period. Each episode lasted between 10 and 30 minutes. Slurred speech is a symptom of carotid artery disease.

77. There are two reports of imaging studies in the record. A CDUS was taken August 10, 2010, and the radiologist reported "significant calcified atherosclerotic plaque with moderate to moderately severe stenosis of the proximal left internal and proximal left external carotid arteries. Might consider obtaining a CTA of the carotid arteries for further evaluation." An MRA of the carotid arteries and an MRA of the head without contrast were taken on August 13, 2010. The same radiologist reported as her relevant impression, "40 to 50% narrowing of the left carotid bulb with mild narrowing of the proximal left internal carotid artery."

78. In a consult letter dated August 18, 2020, Respondent wrote to the referring physician that the MRA showed "about a 60% left internal carotid artery stenosis and very irregular plaque." He recommended proceeding with a left CEA.

In a history and physical authored by Respondent dated August 20, 2010, he reports that "the MRA was done on August 13, 2010, and this demonstrated . . . a moderate left internal

carotid artery stenosis with lots of irregularities of this plaque. The left internal carotid artery is about 60% . . . ."

Respondent performed a left CEA on August 24, 2010. In his operative report, he wrote that testing had showed "stenosis of 60% -70% left internal carotid artery."

79. Complainant alleges that Respondent's care of DC constituted gross negligence, negligence and/or incompetence and/or the failure to maintain adequate and accurate records in the following three respects.

ALLEGATION 1:
Respondent's performance of [CEA] on DC . . . was not indicated given the CDUS and MRA findings, which Respondent incorrectly reported as "about 60%" stenosis.

80. The standard of care for the performance of a CEA in most symptomatic patients is a finding of stenosis of greater than 50%. Here, an inconclusive CDUS was followed by an MRA showing "40 to 50% narrowing of the left carotid bulb with mild narrowing of the proximal left internal carotid artery." MRA's are known to overcall the degree of stenosis, and yet Respondent documented and told others that DC had "about 60%" stenosis in her left carotid artery, and performed a CEA. Drs. Lee and Nathanson reviewed the imaging studies, and found no basis for a conclusion of 60%. If there was truly a concern that the stenosis was greater than 50%, a conventional angiogram (which is invasive, but less so than a CEA procedure) should have been performed. They opined that DC should have been managed medically, and that the performance of the CEA was an extreme departure from the standard of care.

81. Respondent testified that he, too, reviewed the imaging studies themselves, and prior to the surgery. In addition, he asserts that he had extensive discussions with other physicians and that a treatment plan was devised to treat the left internal carotid artery stenosis prior to treating a cerebral artery lesion. In his Board interview, however, he only said that he reviewed the reports from the radiologist. And there is no documentation of the reason for the 60% conclusion or of this more global treatment plan in the medical record. The opinions of Drs. Schwartz, Milner, and Shoor appear to be based at least in part on what Respondent explained to them, and not as much on the medical record, which lessened the value of the opinions. The standard of care requires that a decision to proceed with a CEA must be made following a clear medical indication for the procedure, and the evidence did not establish such in this case.

82. It was established that the performance of a CEA on DC was an extreme departure from the standard of care and gross negligence.

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ALLEGATION 2:
Respondent's documentation of stenosis of "about 60%" without explanation for the basis for his disregard of the radiologist's MRA findings constitutes unprofessional conduct.

83. As previously stated, the degree of stenosis is a crucial fact in determining whether a CEA should be performed. Performance of a CEA requires a clear medical indication and documentation of the indication in the medical record. It was established that the standard of care required Respondent to explain why he concluded that the degree of stenosis was so much greater than stated in the radiology reports so that the record revealed a clear medical indication for performance of the CEA.

84. It was established that Respondent's failure to explain his disregard of the radiologist's findings as regards DC was a departure from the standard of care.

ALLEGATION 3:
Respondent's reporting in his clinical notes and in his correspondence that the August 13, 2010 MRA showed that DC had "about 60%" stenosis was false and/or misleading, and/or a failure to maintain adequate and accurate records, and/or false representations in the medical records.

85. As concluded above, it was established that Respondent's reporting of "about 60%" stenosis in the matter of DC was negligent, and hence unprofessional conduct. It also represented a failure to maintain medical records as required by the standard of care for documentation.

A finding that the negligent act was also false and misleading would imply an element of willful conduct. It was not established to the required standard that Respondent's representations in this regard were deliberately incorrect.

86. It was established that Respondent failed maintain adequate and accurate patient medical records for DC.

Patient SD

87. Patient SD, then a 74-year-old female, was reported by Respondent in a preoperative history and physical as suffering from "some near syncopal events." On one of these occasions, December 2, 2009, she fell and struck her head. She underwent a CAT scan that showed a left frontal hematoma. On December 8, a CDUS was performed and the radiologist reported 26 to 54% stenosis in the right internal carotid artery and 65 to 66% stenosis in the right carotid bulb. The velocity was within normal range. No stenosis percentage was reported for the left internal carotid artery. As regards the left carotid bulb, the radiologist reported "mild plaque formation."

88. On January 8, 2010, Respondent performed a right CEA on SD. In his preoperative history and physical of the same date, he reported that SD's December 8 CDUS

"showed mild left internal carotid artery stenosis but rather severe right internal carotid artery stenosis of about 80%." In his operative report, Respondent reported that the CDUS "demonstrated severe stenosis in the right internal carotid artery. However, irregular plaque may be as tight as 80%."

89. Complainant alleges that Respondent's care of SD constituted gross negligence, negligence and/or incompetence and/or the failure to maintain adequate and accurate records in the following four respects.

ALLEGATION 1:
Respondent's performance of a right CEA on SD was not indicated given that SD was asymptomatic and had normal carotid artery velocities. Based on the CDUS report, SD had minimal stenosis of 26-54% of the right internal carotid artery.

90. Respondent believed that SD's syncope episodes of feeling light-headed and passing out made her symptomatic and that she was at risk for stroke. Syncope can have many causes. It is properly considered when making a differential diagnosis, but it is not a symptom of carotid artery disease according to Rutherford's, other medical literature, and Drs. Lee and Nathanson. As the evidence established that syncope is not a symptom of carotid artery disease, SD is properly evaluated as an asymptomatic patient.

91. A CEA may be indicated for asymptomatic patients with a minimum of 60% stenosis. The imaging studies showed 26 to 54% stenosis in the right internal, but the finding was 65-66% in the right carotid bulb. These results are far below 80%, but are sufficiently high to consider a right CEA.

92. Dr. Lee's opinion that the right artery was "normal" is not substantiated by the record. Dr. Nathanson opined that there was disease in SD's right carotid, but he would have obtained another imaging study as well as a workup on the reported syncope and would not have operated based on the CDUS alone. Dr. Nathanson found a simple departure because the patient did have some degree of disease on the right side, but a workup of the syncope was not done.

93. It was not established to the required standard that Respondent's performance of the CEA was a departure from the standard of care.

ALLEGATION 2:
Respondent's reporting in the medical records that the December 8, 2009, CDUS showed that SD had "severe stenosis" and "about 80%" stenosis of the right carotid artery was false and/or misleading, and/or an inaccurate medical record, and/or false representation.

94. Respondent testified that he interpreted the CDUS report as finding that SD had severe stenosis in her right carotid artery. Asked about writing 80% in his pre-op report, he said that "the number might have been biased by what I saw at the time of surgery," which of course was after the fact and could not be used to justify its inclusion in the pre-op report.

95. The CDUS does contain a conclusion of "severe stenosis," but this reference is insufficient support for Respondent's report of "about 80%" stenosis. Dr. Nathanson found no support for Respondent's report of 80% stenosis, and characterized it as a completely false statement.

96. Respondent's report of SD's stenosis as "about 80%" in his preoperative report was inaccurate. It represented a failure to maintain medical records as required by the standard of care for documentation. A finding that the act was also false and/or misleading would imply an element of willful conduct. It was not established to the required standard that Respondent's representations in this regard were deliberately incorrect.

97. It was established that Respondent failed to maintain accurate adequate and accurate patient records for SD.

ALLEGATION 3:
Respondent's documentation of stenosis of "about 80%" without explanation for his disregard for the radiologist's ultrasound findings constituted gross negligence and/or negligence.

98. As previously found, the degree of stenosis is a crucial fact in determining whether a CEA should be performed. Performance of a CEA requires a clear medical indication and documentation of the indication in the medical record. The standard of care however does not require Respondent to explain why he concluded that the degree of stenosis was so much greater than stated in the radiology reports. Failing to provide such explanation does not constitute gross negligence.

99. It was not established that Respondent's failure to document an explanation for his reporting of stenosis of "about 80%" was below the standard of care and negligent.

ALLEGATION 4:
Respondent's classification of SD as being symptomatic, in that he attributed her near syncopal events to carotid artery stenosis without a full workup or evaluation of the events constituted gross negligence, negligence, and/or incompetence.

100. Respondent's medical record concerning SD contains the inaccurate statement that syncope is symptomatic of carotid artery disease. He also reported in his interview and testified that this is his belief. Respondent's belief is at odds with the other experts and the medical literature. Respondent performed a workup, though he failed to obtain a full workup or evaluation of SD's syncopal events. In his testimony, Dr. Nathanson did not state specifically why the full workup performed by Respondent was inadequate or deficient.

101. It was not established that Respondent's classification of SD as symptomatic due to syncope without first evaluating the syncope was a simple departure from the standard of care and therefore was not negligent. It also does not demonstrate incompetence.

Patient BL

102. On October 7, 2010, Respondent saw BL, then a male age 91, for an evaluation of left internal carotid artery stenosis. He lived independently and was quite physically active. An echocardiogram was taken in 2007, confirming BL had atrial fibrillation. He complained of intermittent syncopal episodes for one to two years. A CDUS taken July 2, 2010, revealed 10% narrowing of the proximal right internal carotid artery and 60% of the left.

Respondent wrote to one of BL's physicians that the CDUS showed "an irregular 60 to 69% stenosis." He also wrote [BL] is neurologically intact. He does describe though syncopal episodes whenever he lifts his left arm over his head. He has a strong radial pulse and no blood pressure discrepancy between the left and right arm and I cannot elicit any vertebral steal syndrome, but he states that this has happened six or seven times this year and with the known carotid artery stenosis, I am recommending that he undergo a carotid endarterectomy.

103. BL chose to have a CEA. In his preoperative history and physical, Respondent reported that the July CDUS showed "50% to 69% left internal carotid artery stenosis. With this being a borderline stenosis, he was followed but since the symptoms are so dramatic and so consistent he was then referred for vascular surgical evaluation and recommended for admission and surgery at this time."

104. Respondent performed a left CEA on October 29, 2010. He noted the same preoperative and postoperative diagnoses: "Symptomatic left internal carotid artery stenosis." The procedure went well and BL was discharged on October 31, 2010.

105. Complainant alleges that Respondent's care of BL constituted gross negligence, negligence and/or incompetence and the failure to maintain adequate and accurate records in the following four respects.

ALLEGATION 1:
Respondent inaccurately and inconsistently reported Patient BL's carotid duplex results, which constitutes inadequate and inaccurate medical records.

106. There was one imaging study on BL, and that stated his degree of stenosis as 60%. Respondent reported the numbers as "50 to 69%" and "60 to 69%", and provided no explanation of the difference between his report and that of the radiologist. The Board's expert did not specifically testify that it was wrong for Respondent to report in terms of a range identified in the ultrasound report or that it was wrong to identify the range and not also include the specific degree of stenosis under the NASCET criteria.

107. It was therefore not established that Respondent failed to maintain adequate and accurate medical records regarding BL.

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ALLEGATION 2:
Respondent's performance of a carotid endarterectomy on patient BL was not indicated given that he was 91 years old, had medical comorbidities, had moderate carotid artery stenosis, and was asymptomatic.

108. Dr. Lee opined that it was an extreme departure for Respondent to perform a CEA on BL for the following reasons: he was asymptomatic, as syncope is not a qualifying symptom; the degree of stenosis was not high enough (he testified that the CDUS showed 50% to 69%); he had atrial fibrillation and "a few other morbid conditions"; and he was 91 years old. Dr. Lee opined that "a reasonable physician would have recommended medical management."

109. It was not established that chronological age is a valid reason for not performing a CEA. The standard of care requires the elderly to be evaluated as individuals.

110. It was not established that BL suffered from "multiple comorbidities." The only documented comorbidity was the atrial fibrillation, which was controlled.

111. Dr. Nathanson would "generously describe [Respondent's] approach as unconventional" and specified the type of information he would need prior to performing a CEA. He credited Respondent for discussing BL's cardiac history, but a workup to rule out cardiac issues as a possible source of the syncope should have been performed, instead of proceeding first to "go after the mild stenosis." Dr. Nathanson pointed out that it is "unusual for cerebrovascular disease in the form of an isolated carotid stenosis to be responsible for a syncopal event." He opined that it is not a departure from the standard of care to operate on a 91-year-old, but it is inaccurate to describe BL as symptomatic, and it was below the standard to proceed with a CEA with this amount of information.

112. Respondent noted that BL had been under the care of two other physicians for a long time. He had a heart monitor for his atrial fibrillation and was "fully functioning." He chopped wood, drove a car, and was a good candidate for surgery if it were indicated. His doctors had referred him to Respondent following workups that showed no other reason for the syncopal episodes, following a CDUS that showed 60% stenosis.

113. Dr. Shoor concurred that regardless of the relationship of the syncope to the stenosis, 60% met the criteria for a CEA, and given the velocity measurements, he read the study as showing 65% stenosis. BL's cardiologist and internist were perplexed by the syncope and although it is not a common symptom of carotid artery disease, they sent him for a CDUS. Dr. Shoor opined that BL was not symptomatic, but that he nonetheless was a candidate for a CEA.

114. Dr. Milner opined that Respondent's performance of the CEA was within the standard of care. He opined that BL's syncopal episodes made him symptomatic. But even if he were not, there was sufficient stenosis reported to support a CEA.

115. Dr. Schwartz agreed that ongoing medical evaluation was indicated and that the CEA might have been indicated. He saw no evidence of lack of knowledge and the affirmative evidence of successful therapy accomplished. Medical and cardiology clearances were obtained,

which is appropriate for elderly patients. It was reasonable for Respondent to rely on their recommendation that he could undergo the CEA.

116. It was not established to the required legal standard that the performance of a CEA on BL was below the standard of care.

ALLEGATION 3:
Respondent's classification of BL as symptomatic was below the standard of care.

117. Respondent wrote that BL's syncope "has happened six or seven times this year and with the known carotid artery stenosis, I am recommending that he undergo a [CEA]." Respondent has consistently stated that syncope is a symptom of carotid artery disease, and the evidence established that it is not.

118. The evidence established that Respondent's classification of BL as symptomatic was a departure from the standard of care and negligent. It was also incompetent.

ALLEGATION 4:
Respondent's attribution of BL's syncopal events to carotid artery stenosis without obtaining a full workup or evaluation of his syncopal events was below the standard of care.

119. Syncope is not a symptom of carotid artery disease; it does not indicate the presence of that disease and can be caused by multiple physical conditions. By his writing and his oral statements that syncope is such a symptom, it is reasonably inferred that Respondent attributed BL's syncopal events to carotid artery stenosis. Dr. Nathanson opined that BL's syncope should have been subjected to a differential diagnosis analysis prior to the performance of a CEA. Dr. Nathanson did not, however, testify specifically as to why the workup performed by Respondent was inadequate or deficient.

120. It was not established that Respondent's failure to fully evaluate BL's syncopal events was below the standard of care and negligence.

Other evidence

121. Keith Korver, M.D., is board certified as a general surgeon and as a cardiac thoracic surgeon. He has been licensed as a physician in California since 1982. Dr. Korver is on the staff of 15 hospitals in the Bay Area, although he is predominantly associated with Sutter Santa Rosa, where he started the heart surgery program.

122. Dr. Korver first met Respondent when they were enrolled in residency programs at UCSF. Respondent moved to Michigan to practice, and they became reacquainted when Respondent returned to California to complete a fellowship at Stanford. Dr. Korver was with Northern California Medical Associates (NCMA) in Santa Rosa, a group of approximately 40 physicians. He had a hand in helping to recruit Respondent, and was very pleased when he joined NCMA. With Respondent, NCMA was able to increase carotid artery operations from

two to three per year to 70 to 80. As a result, a whole new class of patients could be cared for and new techniques were employed at Sutter Santa Rosa.

123. Respondent started NCMA's vascular surgery program, and Dr. Korver assisted him frequently in the beginning as he wanted him to succeed. He noted that Respondent took on long and difficult cases, such as procedures to save the feet of diabetics, which last five or six hours. They worked together for five to six years, and split call duties 50-50, which he notes was a bit unfair because he is not a vascular surgeon.

Dr. Korver opined that Respondent is an excellent technical surgeon and that his judgment in cardiac surgery is excellent. He based his opinion on the many hours they worked together, assisting each other. Dr. Korver believes that of the approximately 50 surgeons he has observed perform carotid artery procedures, Respondent is in the top two or three; "he is superb."

124. Dr. Korver also opined regarding Respondent's personal interactions with patients. He described him as an excellent person and a great partner, who talks easily with others and is very empathetic with patients. Respondent takes constructive criticism, and they talked about failings and successes in their practices. Dr. Korver believes that Respondent exhibited insight and would engage in self-improvement.

125. Mohammad Hossein Mir-Sepasi, M.D., is board certified as a surgeon and a cardiothoracic surgeon. He obtained his medical degree from Johns Hopkins, then returned to his native Iran to practice. Following the Iranian revolution, he immigrated to the United States, practicing first in Virginia. He moved to California in 1999 and joined a group practice. After approximately two years, Dr. Korver approached him regarding working as an assistant in surgical procedures, and Dr. Mir-Sepasi joined NCMA. He assisted Dr. Korver, Respondent, and another surgeon, and also assisted with the after care of surgical patients. He is now retired.

Dr. Mir-Sepasi has known Respondent since 2007, when Respondent joined NCMA. He has assisted Respondent in numerous surgeries. Dr. Mir-Sepasi described Respondent as a "very good technical surgeon in vascular surgery." He has shown good clinical judgment in the operating room and interacts well with other members of the surgical team.

LEGAL CONCLUSIONS

1. Unprofessional conduct is grounds for discipline of a physician's certificate pursuant to Business and Professions Code section 2234. Unprofessional conduct includes gross negligence (Bus. & Prof. Code, § 2234, subd. (b)), repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)), incompetence (Bus. & Prof. Code, § 2234, subd. (d)), and the failure to maintain adequate and accurate patient records (Bus. & Prof. Code, § 2266).

2. The evidence established that Respondent was grossly negligent in the treatment of patients SB, RB, and DC. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (b), by reason of the matters set forth in Findings

54 through 59, 73 through 75 and 80 through 82.

3. The evidence established that Respondent committed repeated negligent acts, in that simple departures from the standard of care were found in his treatment of ~~all five~~ three patients. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (c), by reason of the matters set forth in Findings 50 through 53, 68 through 72, 83, 84, and 117 through 120.

4. In the context of professional licensing, "incompetence" means "a lack of knowledge or ability in the discharging of professional obligations. Often, incompetence results from a correctable fault or defect." (*James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109.) The evidence established that Respondent lacked competence in his treatment of SD and BL. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (d), by reason of the matters set forth in Findings 117 and 118.

5. The evidence established that Respondent failed to maintain adequate and accurate patent records as regards patients SB, DC, SD, and RB. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2266, by reason of the matters set forth in Findings 60, 85, 86, and 94 through 97.

6. As cause for discipline has been established, it remains to determine the appropriate level of discipline to impose. In making this determination, it is recognized that the purpose of these proceedings is to protect the public, not to punish physicians. Depending upon the violations, the goal is to remediate physicians whenever possible.

Before the Board is an experienced and talented vascular surgeon whose care of five patients was below the standard of care in different respects. Other than as needed for hearing scheduling purposes and to describe his career history, the timing of the care of the patients vis-à-vis the tremendous strain and tragedy of Respondent's son's cancer was not discussed. But it is striking that this enormous personal problem was ongoing over roughly the same time period as Respondent's care of the five patients in this case. Although this does not excuse or even mitigate the violations, it does supply important context. It is also noted that Complainant recommends license probation.

It is concluded that the public interest will be served and protected, and that Respondent's practice will be assisted, by a five-year term of probation pursuant to the conditions set forth below.

In assessing penalty on the second remand, the Board is guided by the Superior Court's order. The AGO suggests in its brief that the Board 'reaffirm' its decision and Respondent suggests in his brief that the practice monitor condition of probation be deleted in its entirety and that the term of probation be reduced to two years. The Board respectfully denies Respondent's request, and as for the reaffirmation of its first decision, the course of action to be taken is the fixing of the penalty as instructed by the Court. Respondent will be granted credit for time served under the Board's first decision (unless the probation was stayed by the Court) and will be

credited for those probationary obligations he has already completed. Item 4 of the Order will be recast to be identical to the item in the Board's first decision.

ORDER

Physician's and Surgeon's Certificate No. A44147, issued to Respondent James E. O'Dorisio, M.D., is revoked; however, revocation is stayed and Respondent is placed on probation for five years under the following terms and conditions. The Board recognizes that Respondent has been on probation during the course of this matter's lengthy judicial review, and accordingly, time already served on probation shall be credited toward completion of the probationary period.

1. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine (Program). Respondent shall successfully complete the Program not later than six months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. Determination as to whether Respondent successfully completed the examination or successfully completed the program is solely within Program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, Respondent shall receive a notification from

the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program has been completed. If Respondent did not successfully complete the clinical training program, Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

2. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

3. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

4. Monitoring - Practice

Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name, and

qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

5. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, Respondent's practice setting changes and Respondent is no longer practicing in a setting in compliance with this Decision, Respondent shall notify the Board or its designee within five calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

6. Notification

Within seven days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities, or insurance carrier.

7. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

8. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

11. Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

12. Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

13. License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's certificate.

14. Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to

any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

15. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

16. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws and General Probation Requirements.

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17. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

This Decision shall become effective on September 22, 2017.

IT IS SO ORDERED: August 23, 2017.

Michelle Anne Bholat, M.D., Chair
Panel B

MARVIN FIRESTONE, MD•JD & ASSOCIATES, LLP
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Attorney for: Petitioner James E. O'Dorisio, M.D.

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

James E. O'Dorisio, M.D.,

Petitioner,

vs.

Medical Board of California,

Respondent

Case No. CPF-17-515440

~~[PROPOSED]~~ ORDER GRANTING EX PARTE APPLICATION FOR STAY OF ENFORCEMENT OF ADMINISTRATIVE DECISION

ORDER STAYING ADMINISTRATIVE DECISION IN PART

Petitioner's *Ex Parte* Application for Stay of Administrative Decision was heard in Department 514 of the above-entitled Court on January 9, 2017, the Honorable Joseph M. Quinn presiding. Petitioner appeared by his counsel, Michael A. Firestone, MD•JD & Associates, LLP, and Respondent appeared by its counsel, Kathleen A. Kenealy, Acting Attorney General, by Carolyne Evans, Deputy Attorney General and Jane Zack Simon, Supervising Deputy Attorney General.

After reviewing and considering the moving and opposing papers, and having heard and considered oral argument, and good cause appearing therefor,

IT IS ORDERED that Petitioner's Application for Stay of Administrative Decision is granted in part.

IT IS FURTHER ORDERED that the first sentence of the third paragraph of Term and Condition No. 4 (Monitoring-Practice) found on Page 28 of the Medical Board of California's

Decision After Remand dated December 2, 2016 and effective December 30, 2016 ("Decision After Remand") is stayed pending a resolution of Petitioner's Writ of Administrative Mandate proceeding pending before this Honorable Court. The remaining terms and conditions of the Decision After Remand remain in effect and are not stayed.

IT IS FURTHER ORDERED that during the pendency of the writ proceedings, Respondent Medical Board shall not publish, disseminate, distribute or otherwise to the public (and will retract if it has been published already on the BreEZe online website, the online licensing and enforcement system for the Department of Consumer Affairs), unless and until the first sentence of the third paragraph of Term and Condition No. 4 (Monitoring-Practice) found on Page 28 of the Medical Board of California's Decision After Remand dated December 2, 2016, has been redacted in its entirety.

IT IS FURTHER ORDERED that all public dissemination or distribution relating to the license status of James E. O'Dorisio, M.D. (including posting on the Medical Board's public website [the BREEZE system], any responses to requests for public information or documents, or reports required by law) shall include both the redacted December 2, 2016 Decision After Remand and this Order Granting a Limited Stay.

IT IS SO ORDERED.

Dated: 1/10/2017

Joseph M. Quinn

Honorable Joseph M. Quinn
San Francisco Superior Court

Approved as to Form:

Carolyne Evans
Deputy Attorney General

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: JAMES EDWARD O'DORISIO, M.D. Certificate No. A 44147 Respondent.	)	Case No. 12-2011-217415

DENIAL BY OPERATION OF LAW
PETITION FOR RECONSIDERATION

No action having been taken on the petition for reconsideration, filed by Marvin H. Firestone, M.D., JD., on behalf of James Edward O'Dorisio, M.D., and the time for action having expired at 5 p.m. on December 30, 2016, the petition is deemed denied by operation of law.

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against:	Case No. 12-2011-217415
JAMES E. O'DORISIO, M.D.	OAH No. 2014080414
Physician's and Surgeon's Certificate No. A44147	
Respondent.	

DECISION AFTER REMAND

Administrative Law Judge Mary-Margaret Anderson, Office of Administrative Hearings, State of California, heard this matter on January 5 through 9, and March 2 through 4, 2015, in Oakland, California.

Jane Zack Simon, Supervising Deputy Attorney General, and Carolyne Evans, Deputy Attorney General, represented Complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

Marvin H. Firestone, M.D., Attorney at Law, and Michael A. Firestone, Attorney at Law, represented Respondent James O'Dorisio, M.D., who was present.

The record remained open to allow the parties to file written closing argument. The briefs were timely filed and marked for identification as follows: Complainant's Closing Argument, Exhibit 20; Respondent's Closing Argument, Exhibit DD; and Complainant's Reply, Exhibit 21.

The record initially closed on May 26, 2015, following receipt of Complainant's reply brief.

The record was reopened on July 8, 2015. A conference call was held with counsel to discuss the possibility that a page of an exhibit may have been missing. Respondent's closing brief referenced page 00060 of Exhibit 6, and it could not be located in the record. Counsel were instructed to meet and confer on the issue of page 00060.

On July 15, 2015, Respondent filed a request that page 00060 and newly found office notes be added to the record. On July 16, 2015, Complainant filed an opposition to the request.

Respondent's request and Complainant's opposition were marked for identification in the record as Exhibit EE and Exhibit 22, respectively.

The record closed on July 16, 2015.

On July 28, 2015, the administrative law judge submitted her proposed decision to the Medical Board of California. The board adopted that decision on August 24, 2015, to become effective on September 23, 2015.

Thereafter, respondent filed a Petition for Reconsideration and for Stay. On September 15, 2015, the board granted the stay until October 23, 2015 for the sole purpose of allowing Respondent to file a Petition for Reconsideration. After Respondent filed his Petition for Reconsideration, the board issued an order extending the stay for the purpose of allowing the Board time to review the Petition for Reconsideration. Following its review, on October 29, 2015, the Board issued its Order Denying Petition For Reconsideration effective November 2, 2015.

Respondent subsequently petitioned the Superior Court for a Writ of Administrative Mandamus. On May 6, 2016, the court issued its order granting in part and denying in part the writ petition. The court issued its Judgment on May 25, 2016 remanding the matter to the Board for assessment of the penalty on the basis of the findings and determinations set forth in its Order.

Having reconsidered its Decision pursuant to the court's direction in the Judgment and Order, and after affording the parties the opportunity to make oral and written arguments, the board now makes a modified decision in compliance with the Judgment. A copy of the Judgment and the Order On Petition For Administrative Mandamus is attached as Exhibit A.

EVIDENTIARY RULINGS

RB's operative report, page one-page 00060

1. Exhibit 6 contains portions of patient RB's medical records. Bates-stamped page 00060 is a page from her certified medical records that was included in discovery, but was not originally made a part of Exhibit 6. Respondent, however, referenced page 00060 in his closing brief. The record was reopened and the parties asked to respond to these facts.

2. Page 00060 is the first of two pages of Respondent's operative report following his performance on January 31, 2011, of a right carotid endarterectomy on RB. Respondent requests that page 00060 be included in the administrative record as part of Exhibit 6.

Respondent also requests that uncertified records, described as "Office Notes from 1/28/10, 7/29/10, and 8/26/10" be added to the record. These documents were not provided to

Complainant in discovery, are not authenticated, and are reported to have been recently found.

Complainant objects to the admission of any of the documents.

3. Respondent's request is granted as to the admission of page 00060 as part of Exhibit 6. The merits of a complete administrative record outweigh Complainant's concerns that the late admission prevents specific comment by Complainant's expert and cross-examination of Respondent regarding the document. There is no need for expert analysis of page 00060.

4. Respondent's request is denied as to the admission of the "Office Notes." Good cause does not exist to augment the record with these new documents. To do so without prejudice to Complainant would require re-convening the administrative hearing. Considering all of the relevant facts and argument, it is concluded that the probative value of the additional evidence is substantially outweighed by the undue consumption of time that would be necessary. (Gov. Code, § 11513, subd. (f).)

Admission of Exhibit 19

5. At the last hearing session, Complainant offered a declaration from Kira Parisi (marked as Exhibit 19) as rebuttal evidence. Respondent objected, and a ruling was deferred pending the receipt of argument in the closing briefs.

6. Exhibit 19 was offered to rebut Respondent's testimony that he reviewed imaging studies as to patient SD. It is a declaration from an employee of a radiology laboratory, who asserts that she is "familiar with the record keeping system . . . and if called as a witness, could competently testify" to such matters. She declared that, among other things, she searched the laboratory's records and did not find a request for study images for RB from Respondent or anyone else.

7. Exhibit 19 is a hearsay declaration offered for its truth. Government Code section 11513, subdivision (d), provides that hearsay is admissible to supplement or explain other evidence, but if objected to, is insufficient to support a factual finding unless a hearsay exception applies. Respondent objected to Exhibit 19.

8. Complainant asserts Exhibit 19 qualifies for an exception under Evidence Code section 1272 as evidence of the absence of a business record. It was not established that Exhibit 19 qualifies for admission under Evidence Code section 1272. (See *People v. Dickinson* (1976) 59 Cal.App.3d 314, 318.) It does not meet the criteria for any hearsay exception, and is therefore not admitted as direct evidence.

9. Exhibit 19 is admitted as administrative hearsay. (Gov. Code, § 11513, subd. (d).)

FACTUAL FINDINGS

1. Complainant Kimberly Kirchmeyer issued the Accusation in her official capacity as Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On October 26, 1987, the Board issued Physician's and Surgeon's Certificate No. A44147 to James E. O'Dorisio, M.D. (Respondent). As of November 14, 2014, it was scheduled to expire on April 30, 2015, unless renewed. Respondent is a vascular surgeon.

3. The Accusation alleges that Respondent committed unprofessional conduct (gross negligence, negligence, incompetence, and/or failed to maintain adequate and accurate medical records) in the treatment of five patients. As to two patients, he was alleged to have made false and misleading statements in the medical record. Respondent filed a notice of defense and this hearing followed.

4. The standard of proof applied in making the factual findings is clear and convincing evidence to a reasonable certainty.

Respondent's background

5. Respondent received a bachelor's of science degree from the University of Denver with a double major in chemistry and biology in 1978 and graduated from the University of Colorado Medical School in 1982. While at Colorado, he was influenced by Robert B. Rutherford, M.D., Chief of Vascular Surgery and author of Vascular Surgery, the preeminent textbook. He chose residency programs in accordance with his early interest in vascular surgery: Baylor College of Medicine and Cornell University Medical College. At Baylor, Michael DeBakey, M.D., considered the father of cardiovascular surgery and the inventor of the carotid endarterectomy surgical procedure, was head of the program. Respondent was Dr. DeBakey's personal resident twice.

In 1989, Respondent completed a residency in cardiothoracic surgery at the University of California, San Francisco, Medical School (UCSF). He then moved to Michigan, where he was in private practice until 2005. In the meantime, in 2000, he returned to California for a fellowship in endovascular surgery at Stanford.

In 2005, Respondent moved to California and worked in the Kaiser Permanente system for one year. From 2007 until 2014, he was in private practice with Northern California Medical Associates, Inc., in Santa Rosa. He left the group in May 2014.

6. Respondent estimates that he has performed nearly 10,000 surgical procedures in his career, including at least 1,000 carotid endarterectomy (CEA) surgical procedures. Since moving to California, he believes he has performed over 200 CEA's. One of these patients died, one died following a "re-do," and one patient had a stroke. Respondent testified that he has never been sued for malpractice, but in his Board interview said there was a lawsuit in Michigan in approximately 2002 that was settled for $75,000.

7. Respondent is not board certified. On one occasion he did not pass the written general surgery exam, but subsequent exams were not taken because of family obligations. Respondent is, however, highly trained as a cardiac and vascular surgeon, and has over 25 years of experience.

8. Respondent has had special training in reading carotid ultrasound images. In the mid-1990's he obtained national certification for a laboratory in his community in Michigan. He was medical director of the laboratory, read results there, and continued to do so for non-invasive studies after moving to California.

9. In 2008, Respondent's son, age 16, was diagnosed with a rare form of cancer that had already metastasized. During his initial treatments, Respondent did not change his practice despite supervising his son's care and spending a great deal of time with him. There was some improvement, but he experienced a recurrence in 2010. At that point Respondent changed his schedule to accommodate assisting his son with treatments, including by traveling with him to other cities, sometimes out of state. Respondent reduced his practice of medicine after that date. He also formed a company to conduct research on new treatments for cancer.

10. Respondent's care of the five patients that are the subjects of this case occurred at Sutter Hospital in Santa Rosa. In 2011, concerns were raised by the quality department about complications in CEA's performed by Respondent. Reviews of the cases were undertaken, and restrictions imposed including that Respondent consult with a neurologist before proceeding with surgery. Subsequently, the Medical Executive Committee voted to revoke his hospital privileges. Respondent appealed. Following presentations by both sides, a settlement was offered through a mediation process, and Respondent accepted it. As part of the settlement, Respondent relinquished his privileges at Sutter Santa Rosa.

11. Respondent has hospital privileges at Ukiah Valley Medical Center, with no restrictions. As of the date he testified, he was keeping close control on his hours, to be available for his son.[1] He was working approximately nine to five, unusual for a surgeon, and performing every procedure except cardiac surgery. Respondent was also working at the hospital's wound center, and was set to become the director the following month.

Expert opinion evidence

12. Including Respondent, six physicians, all experts in vascular surgery, opined regarding the standard of care for the performance of CEA procedures and Respondent's care of the five patients. Two of the experts authored written reports.

EUGENE LEE, M.D.

13. Eugene Lee, M.D., is a California licensed physician and surgeon, and is board certified in vascular surgery. He received his medical degree from Tufts University in 1994, and

[1] Respondent's son passed away on May 15, 2015

completed a general surgery residency at the University of Minnesota in 2002 and a fellowship in vascular surgery at Stanford Medical School in 2004. Dr. Lee is the Chief of Vascular and Endovascular Surgery at the Sacramento Veterans Affairs Medical Center, and he performs CEA's at that facility two to three times weekly. He is also an Associate Professor in the Department of Surgery at the University of California at Davis Medical Center. Dr. Lee is an active member of the Society of Vascular Surgery and many other professional organizations. He is extensively published in peer-reviewed journals, and has authored two book chapters. Dr. Lee testified at hearing and also authored a written report.

DANIEL NATHANSON, M.D.

14. Daniel Nathanson, M.D., is a California licensed physician and surgeon, and is board certified in vascular surgery. He received his medical degree from Pennsylvania State University College of Medicine in 1997, and completed general surgical residencies at both St. Vincent's Hospital and Medical Center in New York (2000) and Brigham and Women's Hospital in Boston (2004). Dr. Nathanson completed a fellowship in vascular surgery at UCSF in 2007. He is the Director of the Endovascular Surgery Program at California Pacific Medical Center. He is also a Clinical Associate Professor at UCSF, where he teaches vascular surgery to general surgery residents.

LEWIS SCHWARTZ, M.D.

15. Lewis Schwartz, M.D., is licensed as a physician in Illinois, Michigan, Massachusetts, and North Carolina, and is board certified in general surgery and vascular surgery. He was licensed in California at one time, but has not practiced here. He received his medical degree from the University of Chicago Pritzker Medical School in 1987. He completed a surgical residency at Duke University Medical Center in 1994, and a fellowship in vascular surgery at Brigham and Women's Hospital in Boston in 1995. He has taught surgery at the University of Chicago in one position or another since approximately 2002. His current title is Clinical Associate Professor. He currently performs surgery one week each month. Dr. Schwartz is a distinguished fellow of the Society of Vascular Surgery and is on the editorial board of the Journal of Vascular Surgery. He is extensively published.

Dr. Schwartz met Respondent approximately 20 years ago when Respondent was practicing cardiac and vascular surgery in Michigan. In addition to reviewing the patient records, expert reports and other documents in evidence, he discussed the case with Respondent and was present for most of the hearing. He testified and authored a written report. Dr. Schwartz is of the opinion that Respondent is a talented surgeon.

PERRY M. SHOOR, M.D.

16. Perry M. Shoor, M.D., is a California licensed physician and surgeon and is board certified in vascular surgery. He received his medical degree from The Chicago Medical School (now the University of Health Sciences) in 1971. He completed a surgical residency followed by a fellowship at University of California, San Diego, in 1978. Dr. Shoor completed a fellowship in peripheral vascular surgery at Stanford in 1979. He practiced as a vascular surgeon from 1979

until 2010, when a hand injury ended his surgical practice. Dr. Shoor estimates he has performed between 1,100 and 1,200 CEA's in his career. He is a member of the Society of Vascular Surgery, and is a published author of articles and book chapters.

ROSS MILNER, M.D.

17. Ross Milner, M.D., is licensed as a physician in Illinois. He received his medical degree from the University of Pennsylvania in 1994, and completed a surgical residency and a fellowship in vascular and endovascular surgery at the same institution. Dr. Milner was the program director for the vascular surgery fellowship program at Emory University for seven years, then became chief of vascular surgery at Loyola University Medical Center in Chicago. Currently, he is a full professor at the University of Chicago Medical Center, where he also practices surgery between 60 and 70 hours per week. Dr. Milner is extensively published, with approximately 80 peer-reviewed articles and over 20 textbook chapters. He estimates he has performed over 500 CEA's in his career, with the most recent occurring in February 2015.

ADDITIONAL EXPERT EVIDENCE

18. In addition to the expert testimonial evidence, the factual findings are informed by *Rutherford's Vascular Surgery,* seventh edition, chapter 95, "Carotid Artery Disease: Endarterectomy" (Rutherford's). It was undisputed that Rutherford's is the authoritative textbook in the specialty. In addition, information from peer-reviewed journal articles in evidence, as explained or referenced by the expert witnesses, also informed certain factual findings. These include guidelines issued by the Society for Vascular Surgery issued in 2008 (SVS Guidelines).

Analysis of expert opinions

19. Although the experts' opinions varied as to the standard of care to some extent, they did not differ in many respects. All of the experts offered valuable information and rendered opinions that were persuasive to various degrees. As no expert was entirely persuasive or not persuasive, a general finding to that effect is not made. Each expert's opinion was carefully considered in making each finding, whether or not the particular expert's opinion is reported in the factual finding.

Overview of procedures to treat blockages of the carotid artery

20. Vascular surgeons treat carotid artery disease. The carotid artery is located in the neck, between the ear and lower neck. It provides oxygenated blood from the heart to the brain. There are three main segments of the carotid artery: the common carotid artery (CCA), the internal carotid artery (ICA), and the external carotid artery (ECA). The carotid bulb is the point where the CCA bifurcates into two branches and becomes wider.

21. This matter primarily involves Respondent's performance of CEA's, which treat stenosis (narrowing or constricting of the diameter) of the carotid artery. Cholesterol plaque (also called atherosclerosis or blockage) can form in the carotid artery and the resulting stenosis

can inhibit or block blood flow. The plaque itself, or blood clots attached to it, can break off and travel to the brain through the ICA, and cause a stroke.

22. There are two surgical approaches used to treat patients with stenosis. One is carotid stenting. A balloon is inflated within the artery, expanding a stent, which compacts the plaque against the wall of the artery, preventing it from breaking off. The other is the CEA.

23. To perform a standard CEA, the surgeon opens the carotid artery and removes plaque, generally following a longitudinal incision. Opening the artery cross-wise is called the eversion technique. Whichever method is used, the artery is closed with sutures in the arterial wall or with a patch.

24. CEA's are dangerous surgeries. The risks include bleeding, stroke and death. They should only be performed for patients with high levels of stenosis and where it is clear that the risk of stroke will be reduced; in other words, when the potential benefit outweighs the risk of surgery.

25. Different types of imaging studies may be conducted to show the degree of stenosis, and each have risks, benefits, and costs. They also report the degree of stenosis in different ways. The carotid duplex ultrasound (CDUS) is considered accurate and reliable, and is non-invasive. It is a duplex study because it reports both a picture of the artery, which can reveal the character of the plaque, and the degree of velocity, which gauges the amount of stenosis by how fast the blood is flowing through the artery. An instrument uses ultrahigh-frequency sound waves to penetrate the skin, and applies the Doppler principle to estimate the velocity of blood flowing through the artery. The higher the velocity is, the higher the degree of stenosis. The velocity is reported, and a color-coded two-dimensional image of the artery is provided, which shows the shape and size of the plaque. The colors represent blood flow direction. The estimate of the amount of stenosis is given in a range, such as 60 to 70%. In most cases, a CDUS is the only imaging study needed to evaluate a patient for a CEA.

The magnetic resonance angiogram (MRA), a study using magnetic resonance imaging, is also noninvasive, but may overestimate the degree of stenosis. An MRA gauges the size of the plaque and the lumen (the cavity of the vessel) by how fast protons are spinning inside the cells.

Other types of studies are quite invasive. A computed tomographic angiogram (CTA), also called a CAT scan with angiography, is more expensive, and requires the infusion of a chemical dye. And a conventional angiogram requires puncturing a femoral artery in the groin to thread a catheter to the base of the neck. Contrast dye is injected into selected arteries and x-rays show the location and extent of blockage.

26. Radiologists interpret imaging studies and issue written reports of their findings. Other medical specialists can also interpret imaging studies, depending upon their training and experience. Vascular surgeons generally are so trained, and can have valid opinions that can differ from the radiologist's interpretation.

27. A completion study is a test performed after the CEA procedure is completed. It

is an objective test and can consist of any of the studies discussed above, performed in the operating room, or later when and if the patient exhibits neurological defects. A continuous wave Doppler (CWD) can be used as a completion study, but it does not result in an image that can be studied.

Indications for CEA for asymptomatic patients

28. The goal of a CEA is to reduce the risk of stroke. The main risk factors for strokes caused by carotid atherosclerotic disease are the presence of related symptoms and the degree of carotid stenosis. Studies have been conducted and guidelines issued by professional societies to help determine what degree of stenosis warrants the risk of a CEA procedure. The degree is very important in making that decision, but the relevance of the degree varies depending upon other factors, including whether the patient has symptoms that are signs of carotid artery disease; in other words, whether the patient is symptomatic or asymptomatic. It is a somewhat controversial and evolving area of study as to what degree of stenosis warrants the invasive procedure of a CEA, and what does not, particularly in an asymptomatic patient.

29. As regards symptomatic patients, the consensus is that a CEA is beneficial where the stenosis is severe. For asymptomatic patients, the benefits of CEA are less clear and the degree of stenosis that establishes benefit is not as well established. Nonetheless, Rutherford's and the SVS Guidelines are consistent. They assert that significant benefit has been established for asymptomatic patients with stenosis equal to or greater than 60%. Each of the retained experts in this matter agreed, although Dr. Nathanson identified it somewhat differently as 60 to 70%. And in his interview, Respondent identified the degree of stenosis as 70% or greater, but added that "there are certainly very large studies that use 60% asymptomatic as their cutoff."

Dr. Lee, however, introduced a qualifier to the guidelines because of his understanding that the studies underlying the conclusion used angiographic results to report the degree of stenosis. He asserts that an angiogram result of 60% correlates with 80% in a CDUS, and that therefore a CDUS of equal to or greater than 80% is needed before a CEA can be recommended for an asymptomatic patient. He was adamant on this point, stating that it is well understood by vascular surgeons, and that there is no confusion regarding this matter. Dr. Lee's references to the literature to reinforce his opinion, however, were not successful, and Dr. Schwartz was equally adamant that it was incorrect. Dr. Schwartz opined that there is no expectation that an ultrasound that reads 80% is actually 60%; that the expectation is that the correlation is one-to-one. Dr. Lee was not persuasive on this point.

30. According to Rutherford's and other sources, there is no consensus on which imaging modality is the most accurate for determining the degree of stenosis. There are studies that report some evidence for better accuracy from each of the CDUS, MRA, and the CTA modalities. There is evidence that the MRA overestimates degree, which makes it harder to differentiate more moderate from severe stenosis. On the other hand, as stated above, the CDUS is now the most commonly used imaging study when evaluating a patient for a CEA, and procedures are commonly done following the CDUS alone.

31. There are instances, however, when one study is insufficient. On the subject of when there is a need for additional imaging testing, Rutherford's concludes:

> Clearly, if the patient is found to have an intermediate stenosis and is asymptomatic, one should perform at least another noninvasive test to confirm this finding before recommending CEA. If there is discordance between these studies, one should either obtain a third non-invasive test or resort to angiography. . . .

The SVS Guidelines concur. Specifically as to the CDUS, they recommend additional imaging studies before surgical intervention where the degree is reported in the intermediate range of 50% to 69%.

32. Regardless of the imaging study used and the degree of stenosis reported, the decision to perform a CEA is made based upon all of the available data. This includes information specific to the individual patient, such as is gleaned by history and physical examination and other tests, other conditions the patient may have, the patient's personal preferences, and the surgeon's judgment based on training and experience. In other words, the decision is not properly made based upon the results of an imaging study standing alone.

Patient SB

33. Patient SB,[2] an 80-year-old male, first presented to Respondent on March 4, 2010, for a consultation. He had a previous history of stoke and left CEA eight years prior. SB did not report any transient ischemic attacks (TIA), syncope (fainting), or new weaknesses. SB had residual weakness in his right arm, but otherwise functioned well.

34. A CDUS on February 11, 2010, revealed 50% to 69% stenosis of the right internal carotid artery and 80% to 90% restenosis of the left internal carotid artery, with peak velocities over 600 cm/sec. Respondent noted[3] that he discussed the option of carotid stenting with SB, but that SB wanted to have a second CEA. Respondent did not obtain any additional imaging studies.

35. On March 19, 2010, Respondent performed a "re-do" left CEA on SB. He noted that it was a long and difficult operation. Instead of plaque, which can be removed, Respondent found neointimal hyperplasia, which cannot. A classic CEA was therefore not performed; instead, Respondent widened the artery, using a patch angioplasty.

36. There is no indication in SB's medical record that an assistant was present for the surgery.

37. Respondent did not obtain a completion study following the procedure.

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[2] Patients are referred to by numbers to protect privacy.

[3] "Noted" means Respondent entered the information in a patient's medical record.

38. At 10:30 p.m., Respondent made the first post-operative note, containing status information such as that the procedure was a left CEA re-do with a Dacron patch repair with no complications. He also noted that SB's right arm is slightly weaker than his left from an old stroke, and that "this is his base line." At 11:30 p.m., approximately one hour after the surgery, Respondent noted that SB: was slow to wake in the recovery room; had occasional left arm and leg movement but the right side was quiet; that he was not yet responding to verbal commands; and that he had an interrupted breathing pattern. The experts agree that these observations were consistent with a stroke. Respondent testified that he consulted with a neurologist and intensivist (the physician assigned to the intensive care unit, or ICU) in the early morning hours, and it was decided that SB would remain in the ICU and receive intravenous heparin (a blood thinner) with the hope of dissolving the clot that was blocking the flow to the brain and preventing further clot formation. Respondent, however, did not document a treatment plan, and made no further chart notes until the following day.

39. Another physician ordered a CT imaging study at approximately 4:35 a.m. the next morning, which showed an occluded left carotid artery.

40. A CDUS taken March 20, 2010, showed complete occlusion of the left common and internal carotid arteries. A CT scan of SB's head on March 21, 2010 showed a massive stroke. SB died on March 23, 2010.

41. Respondent's operative report states that it was dictated on April 7, 2010.

42. Complainant alleges that Respondent's care of SB constituted gross negligence, negligence and/or incompetence and the failure to maintain adequate and accurate records in the following five respects.

ALLEGATION 1:
Preoperatively, Respondent did not obtain appropriate imaging studies, such as a CT angiogram.

43. Dr. Lee opined that Respondent's failure to obtain another imaging study, specifically a neck and chest CT angiography, prior to performing the CEA was below the standard of care. That test would have revealed the extent of internal carotid artery disease and arch anatomy, which informs the decision of which procedure, if any, should be performed. As the lesion was on the neck, in this instance the test would not have contributed very much relevant information, but should have been performed. Dr. Nathanson concurred with this opinion, reasoning that a CTA helps to show the location of the disease, and helps in the decision of whether the patient is a candidate for a stent. He cannot "think of anytime I did a re-do without additional imaging studies." In addition, he believes that such studies assist when discussing the options with the patient.

44. Respondent, and Drs. Schwartz, Milner and Shoor, disagree. They concur that the CDUS provides sufficient information to proceed with a CEA, even a re-do. An angiogram would be indicated if a stent was planned, but was not necessary in this case. It was clear that there was a very high degree of stenosis and that SB preferred a CEA over other procedures.

Patient SB had been referred from another physician, who had done a thorough work-up.

45. The CDUS result was 80 to 90% restenosis in the left carotid; it was not disputed that a CEA was warranted. As regards additional imaging studies, the literature recommends such be done where the result shows moderate stenosis, not severe. It is concluded that obtaining an additional imaging study prior to the CEA was at the surgeon's discretion.

46. It was not proven to the required standard that the failure to obtain additional imaging studies prior to performing a CEA in the case of SB was below the standard of care.

ALLEGATION 2:
Respondent did not provide proper counseling to SB prior to surgery.

47. Dr. Lee opined that the lack of a second pre-surgical imaging study meant that SB did not have sufficient counseling prior to surgery.

48. Respondent's notes dated March 4, 2010 state: "Option of current stenting discussed with the patient and he has no interest in carotid stenting and would like to proceed with carotid surgery. All risks and benefits were discussed. Will plan for this." Respondent testified that he discussed the surgical options and the risks and benefits of a re-do CEA, as well as stenting, with SB. Respondent could have performed either procedure. SB, however, was strongly opposed to stenting, because of stories from friends and family members who had bad outcomes.

49. It was not proven that Respondent's pre-surgical counseling of SB was below the standard of care.

ALLEGATION 3:
Intraoperatively, Respondent failed to obtain and/or document a completion imaging study in the operating room at the conclusion of the operation.

50. Dr. Lee asserted that an imaging study should have been obtained given the difficulty of the procedure, and SB's history and condition. Drs. Lee and Nathanson opined that Respondent's failure was a departure from the standard of care.

51. Respondent explained that he always uses continuous wave Doppler, which is a type of completion study. He uses the Doppler in conjunction with a "look, listen and feel" method to assess the patient's condition. There is no image to look at, but his trained ear recognizes the appropriate sounds and can assess the patient.

52. It is recognized that a continuous wave Doppler is a type of completion study, but it is not an imaging study. SB's surgery, the second attempt to clear stenosis, was described by Respondent as one of his most difficult in five years. Although the decision to proceed with surgery was supportable, the risk of stroke was great. Technical problems with the procedure can increase the risk of stroke. It was incumbent upon Respondent to obtain the information revealed by an imaging study before concluding the procedure.

53. It was proven that Respondent's failure to obtain and document a completion imaging study of SB was below the standard of care.

ALLEGATION 4:
Post-operatively, when it was observed that SB had neurologic deficits, Respondent failed to properly evaluate, diagnose, or exclude a technical problem. The standard of care is to manage the problem immediately, with either urgent carotid duplex study or re-exploration of the carotid artery. Neither was done.

54. A post-operative stroke is almost always caused by a technical error during surgery. An imaging study post-procedure might have identified issues that needed correction, but none was done immediately, or even after SB evidenced neurological problems at 11:30 p.m. Once the deficit was noticed, Respondent might have returned SB to the operating room, re-sectioned the segment of diseased artery and placed a graft. Dr. Lee opined that SB should have been evaluated prior to leaving the operating room, and certainly immediately following the observation of neurological deficits at approximately 11:30 p.m.

55. There is scant evidence in the medical record of Respondent's attention to SB post-operatively. Respondent does not recall if he remained at the hospital. He testified that he remained involved and "would have" discussed the case with the intensivist. In sum, Respondent asserts that he and the intensivist discussed the case, he decided not to go back to the operating room, and decided that SB would remain in the recovery room and receive heparin. None of this is documented, except the fact that heparin was given. The records show that another physician ordered a CDUS at 4:30 a.m. the following morning, five hours after the deficits were observed.

56. Respondent's position that his care met the standard is belied by a statement in his interview. He said that he "would typically order the two tests that were ordered to try to help me make that decision. That is a carotid ultrasound and CT scan." In fact, it appears that the experts agreed that Respondent did not have sufficient information to determine that it was futile to return SB to the operating room at the time he asserts that he made that decision.

57. Dr. Schwartz's opinion that the post-operative treatment of SB was within the standard of care was based upon studies showing a lack of benefit from re-exploration following observation of a new deficit. He appears to miss the point. The issue is Respondent's post-operative management of the patient, including during the time period before the stroke was confirmed. And Respondent's argument that the record supports a conclusion that the stroke occurred perioperatively is not supported by the evidence.

58. Dr. Nathanson succinctly described the standard of care when he described what he would have done if SB was his patient: that he would sit bedside and establish whether or not a neurologic event had occurred, obtain an emergent CDUS, and either take the patient back to the operating room, or decide not to do so.

59. The evidence established that Respondent's post-operative care of SB constituted an extreme departure from the standard of care and gross negligence.

ALLEGATION 5:
Respondent's failure to dictate his operative report in a timely manner, his failure to document the presence of an assistant during the procedure, his failure to document a completion study (if one was done), and his failure to document a treatment plan when neurological deficits were observed constitutes unprofessional conduct and the failure to maintain adequate and accurate medical records.

60. The standard of practice requires physicians to make and maintain accurate and sufficient medical records for their patients. A 20-day delay in dictating or writing an operative report violates this standard. Timeliness, which generally assists in accuracy, is particularly important in the case of a patient who has undergone a complex and difficult surgical procedure, and who will then be followed by other health care professionals in the crucial time immediately following the surgery. Respondent argues that dictation of reports sometimes does not get transcribed, and that he has had to re-dictate reports in the past, although there is no evidence that this occurred in SB's case. He also argues that when something is always done, for example, having an assistant for the procedure, it is not necessary to be documented. This assertion is not accepted.

In the report he eventually prepared, Respondent failed to document the completion studies he asserts he performed, and the treatment plan he decided upon with the intensivist. He failed to mention that he had an assistant, and who the assistant was. (It is noted that in the case of patients RB and SD, the same operative report format was used by Respondent, and there is a category identified as "ASSISTANT" followed by the name of a physician.) His notes immediately following the surgery were cursory.

61. It was established that Respondent failed to maintain adequate and accurate records for SB.

Patient RB

62. Patient RB, then a 66-year-old woman, saw Respondent for a consultation in 2010. She had a prior history of stroke. On August 13, 2010, Respondent performed a left CEA. On October 5, 2010, he performed an abdominal aortic and bilateral iliac balloon angioplasty. RB was a continuing patient of Respondent's and he asserts he knew her well.

63. On December 16, 2010, RB saw Respondent for a follow-up examination and a CDUS taken December 10 was discussed. The report showed 70 to 80% stenosis in RB's right internal carotid artery. Respondent wrote RB's physician that the report showed "progressive stenosis of the right side, now approaching 80%." She was asymptomatic. He recommended a right CEA and RB agreed.

64. Respondent performed a right CEA on January 31 through February 1, 2011. In one operative report, in the Indication section, Respondent wrote that RB had multiple

cardiovascular problems, including bilateral carotid disease. She has had a previous stroke that involved weakness of her left arm and leg. Symptoms mostly had resolved over the years. She more recently had a left carotid endarterectomy for severe internal carotid artery stenosis and *now is brought in for elective right carotid endarterectomy for a greater than 80% right internal carotid artery stenosis.* [Emphasis added.]

65. The procedure went well, but post-operatively RB evidenced a neurologic deficit. A CDUS was obtained that showed compromised flow. Respondent undertook a re-exploration that was very difficult. He found RB's artery to be "friable," which means very fragile, thin, and/or falling apart. He used a saphenous vein from her left ankle to replace a segment of the artery and inserted a self-expanding stent.

Respondent did not obtain a completion study after the procedure.

In another operative report in the Indications section, Respondent wrote that RB had experienced a good postoperative result from the left CEA, and that "She also now has a progressing, now about 80%, right carotid stenosis."

66. On February 2, 2011, RB died following a stroke. In a death summary, Respondent wrote that RB had "progressive stenosis now of the right side . . . ."

67. Complainant alleges that Respondent's care of RB constituted gross negligence, negligence and/or incompetence and the failure to maintain adequate and accurate records in the following three respects.

ALLEGATION 1:
Respondent inaccurately and inconsistently reported patient RB's carotid duplex results, including the degree of stenosis.

68. The consult letter Respondent wrote on December 16, 2010, states: "Her follow-up carotid ultrasound . . . also shows, though, progressive stenosis of the right side, now approaching 80%. [RB] is asymptomatic but because of her progressive stenosis on the right side we have discussed elective right carotid endarterectomy . . . ."[4] In one operative report, Respondent wrote that RB had "a greater than 80% right . . . stenosis," and in another that she had "a progressing, now about 80%, right carotid stenosis." The death report states that "she had progressive stenosis now of the right side." In his report to the Sutter Medical Executive Committee, Respondent wrote that RB had a right CEA "for an 80% stenosis."

69. As stated in Finding 63, the CDUS reported stenosis of 70 to 80%. To report the stenosis as greater than 80% was therefore inaccurate. The degree of stenosis is a very important factor in determining whether to proceed to surgery, particularly where, as here, a patient is asymptomatic. If his opinion of the degree differed from the radiologist's, he should have

[4] Respondent's closing brief quotes the letter as follows: "patient is asymptomatic, however, due to the progressive stenosis on the right side, a right CEA was recommended." This quote is inaccurate.

written the opinion in the record. Respondent argues that at least in the operative report, his description of the degree of stenosis likely came from his own observations during surgery. But this argument is belied by his statement in his interview, when he said that he could "get a feeling of how much . . . plaque is there. But because you have disrupted it . . . I could not look down the barrel and say . . . it was 80%, because it could look 90% now or . . . 70% now."

70. It was established that Respondent's report of RB's CDUS results was inaccurate, and that this violated the standard of care.

ALLEGATION 2:
Respondent inaccurately reported that RB's carotid duplex showed progressive stenosis of the right carotid artery.

71. Respondent reports four times in the medical record that RB's stenosis in her right carotid was "progressive," but no other evidence supports these statements. Respondent asserts that he based the characterization on his initial performance of a left CEA, and by following her over the subsequent year. Respondent followed up with examinations concerning all of RB's vascular issues, one of which was carotid artery disease. He believed that she had progressive disease in that she had known carotid stenosis and the most recent CDUS had shown narrowing that caused a recommendation for surgery. The left was at less than 40% after surgery, but the right was 70 to 80%, which showed significant disease, sufficient so that she was a candidate for a right CEA. Further, Respondent's consult letter implies that his conclusion that the stenosis increased in the four months between the studies is supported by a comparison of older and newer studies. But there is no older study in the medical record. Dr. Lee's opinion that Respondent's description of the stenosis as progressive was inaccurate and below the standard of care was persuasive.

72. It was established that Respondent's report that RB's CDUS showed "progressive" stenosis was inaccurate, and that this violated the standard of care.

ALLEGATION 3:
Post-operatively, Respondent failed to obtain a completion imaging study in the operating room at the conclusion of the second operation, which is an extreme departure from the standard of care.

73. RB initially did well following the right CEA on January 31, 2011, but as first described above, she was returned to the operating room when she exhibited a neurologic deficit. Immediately prior to and during the second operation, Respondent employed imaging studies and monitoring to assist him that included a CT scan of RB's brain, cerebral monitoring and a series of intraoperative arteriograms. Respondent also utilized his usual method of continuous wave Doppler, and "look, listen and feel." He did not obtain a completion imaging study at the conclusion of the operation.

74. Drs. Lee and Nathanson again opined that a completion imaging study should have been obtained. They described the intra-operative studies as insufficient to satisfy this requirement. This was not a routine procedure. Respondent performed an end-to-end

anastomosis on the artery with a vein graft. An arteriogram revealed a size mismatch between the artery and the vein at the transition point. Given the level of difficulty, the possibility of difficulty with blood flow through the vessel was greater. After the stent was deployed and flow reestablished, a post-intervention angiogram that included all portions of the artery should have been done. Drs. Lee and Nathanson were persuasive that this was an extreme departure.

75. It was established that the failure to do a post-procedure, completion imaging study was an extreme departure from the standard of care and gross negligence.

Patient DC

76. Respondent first saw female patient DC, then 71 years old, on August 18, 2010. She reported having two episodes of slurred speech within a three-week period. Each episode lasted between 10 and 30 minutes. Slurred speech is a symptom of carotid artery disease.

77. There are two reports of imaging studies in the record. A CDUS was taken August 10, 2010, and the radiologist reported "significant calcified atherosclerotic plaque with moderate to moderately severe stenosis of the proximal left internal and proximal left external carotid arteries. Might consider obtaining a CTA of the carotid arteries for further evaluation." An MRA of the carotid arteries and an MRA of the head without contrast were taken on August 13, 2010. The same radiologist reported as her relevant impression, "40 to 50% narrowing of the left carotid bulb with mild narrowing of the proximal left internal carotid artery."

78. In a consult letter dated August 18, 2020, Respondent wrote to the referring physician that the MRA showed "about a 60% left internal carotid artery stenosis and very irregular plaque." He recommended proceeding with a left CEA.

In a history and physical authored by Respondent dated August 20, 2010, he reports that "the MRA was done on August 13, 2010, and this demonstrated . . . a moderate left internal carotid artery stenosis with lots of irregularities of this plaque. The left internal carotid artery is about 60% . . . ."

Respondent performed a left CEA on August 24, 2010. In his operative report, he wrote that testing had showed "stenosis of 60% -70% left internal carotid artery."

79. Complainant alleges that Respondent's care of DC constituted gross negligence, negligence and/or incompetence and/or the failure to maintain adequate and accurate records in the following three respects.

ALLEGATION 1:
Respondent's performance of [CEA] on DC . . . was not indicated given the CDUS and MRA findings, which Respondent incorrectly reported as "about 60%" stenosis.

80. The standard of care for the performance of a CEA in most symptomatic patients is a finding of stenosis of greater than 50%. Here, an inconclusive CDUS was followed by an MRA showing "40 to 50% narrowing of the left carotid bulb with mild narrowing of the

proximal left internal carotid artery." MRA's are known to overcall the degree of stenosis, and yet Respondent documented and told others that DC had "about 60%" stenosis in her left carotid artery, and performed a CEA. Drs. Lee and Nathanson reviewed the imaging studies, and found no basis for a conclusion of 60%. If there was truly a concern that the stenosis was greater than 50%, a conventional angiogram (which is invasive, but less so than a CEA procedure) should have been performed. They opined that DC should have been managed medically, and that the performance of the CEA was an extreme departure from the standard of care.

81. Respondent testified that he, too, reviewed the imaging studies themselves, and prior to the surgery. In addition, he asserts that he had extensive discussions with other physicians and that a treatment plan was devised to treat the left internal carotid artery stenosis prior to treating a cerebral artery lesion. In his Board interview, however, he only said that he reviewed the reports from the radiologist. And there is no documentation of the reason for the 60% conclusion or of this more global treatment plan in the medical record. The opinions of Drs. Schwartz, Milner, and Shoor appear to be based at least in part on what Respondent explained to them, and not as much on the medical record, which lessened the value of the opinions. The standard of care requires that a decision to proceed with a CEA must be made following a clear medical indication for the procedure, and the evidence did not establish such in this case.

82. It was established that the performance of a CEA on DC was an extreme departure from the standard of care and gross negligence.

ALLEGATION 2:
Respondent's documentation of stenosis of "about 60%" without explanation for the basis for his disregard of the radiologist's MRA findings constitutes unprofessional conduct.

83. As previously stated, the degree of stenosis is a crucial fact in determining whether a CEA should be performed. Performance of a CEA requires a clear medical indication and documentation of the indication in the medical record. It was established that the standard of care required Respondent to explain why he concluded that the degree of stenosis was so much greater than stated in the radiology reports so that the record revealed a clear medical indication for performance of the CEA.

84. It was established that Respondent's failure to explain his disregard of the radiologist's findings as regards DC was a departure from the standard of care.

ALLEGATION 3:
Respondent's reporting in his clinical notes and in his correspondence that the August 13, 2010 MRA showed that DC had "about 60%" stenosis was false and/or misleading, and/or a failure to maintain adequate and accurate records, and/or false representations in the medical records.

85. As concluded above, it was established that Respondent's reporting of "about 60%" stenosis in the matter of DC was negligent, and hence unprofessional conduct. It also

represented a failure to maintain medical records as required by the standard of care for documentation.

A finding that the negligent act was also false and misleading would imply an element of willful conduct. It was not established to the required standard that Respondent's representations in this regard were deliberately incorrect.

86. It was established that Respondent failed maintain adequate and accurate patient medical records for DC.

Patient SD

87. Patient SD, then a 74-year-old female, was reported by Respondent in a preoperative history and physical as suffering from "some near syncopal events." On one of these occasions, December 2, 2009, she fell and struck her head. She underwent a CAT scan that showed a left frontal hematoma. On December 8, a CDUS was performed and the radiologist reported 26 to 54% stenosis in the right internal carotid artery and 65 to 66% stenosis in the right carotid bulb. The velocity was within normal range. No stenosis percentage was reported for the left internal carotid artery. As regards the left carotid bulb, the radiologist reported "mild plaque formation."

88. On January 8, 2010, Respondent performed a right CEA on SD. In his preoperative history and physical of the same date, he reported that SD's December 8 CDUS "showed mild left internal carotid artery stenosis but rather severe right internal carotid artery stenosis of about 80%." In his operative report, Respondent reported that the CDUS "demonstrated severe stenosis in the right internal carotid artery. However, irregular plaque may be as tight as 80%."

89. Complainant alleges that Respondent's care of SD constituted gross negligence, negligence and/or incompetence and/or the failure to maintain adequate and accurate records in the following four respects.

ALLEGATION 1:
Respondent's performance of a right CEA on SD was not indicated given that SD was asymptomatic and had normal carotid artery velocities. Based on the CDUS report, SD had minimal stenosis of 26-54% of the right internal carotid artery.

90. Respondent believed that SD's syncope episodes of feeling light-headed and passing out made her symptomatic and that she was at risk for stroke. Syncope can have many causes. It is properly considered when making a differential diagnosis, but it is not a symptom of carotid artery disease according to Rutherford's, other medical literature, and Drs. Lee and Nathanson. As the evidence established that syncope is not a symptom of carotid artery disease, SD is properly evaluated as an asymptomatic patient.

91. A CEA may be indicated for asymptomatic patients with a minimum of 60% stenosis. The imaging studies showed 26 to 54% stenosis in the right internal, but the finding

was 65-66% in the right carotid bulb. These results are far below 80%, but are sufficiently high to consider a right CEA.

92. Dr. Lee's opinion that the right artery was "normal" is not substantiated by the record. Dr. Nathanson opined that there was disease in SD's right carotid, but he would have obtained another imaging study as well as a workup on the reported syncope and would not have operated based on the CDUS alone. Dr. Nathanson found a simple departure because the patient did have some degree of disease on the right side, but a workup of the syncope was not done.

93. It was not established to the required standard that Respondent's performance of the CEA was a departure from the standard of care.

ALLEGATION 2:
Respondent's reporting in the medical records that the December 8, 2009, CDUS showed that SD had "severe stenosis" and "about 80%" stenosis of the right carotid artery was false and/or misleading, and/or an inaccurate medical record, and/or false representation.

94. Respondent testified that he interpreted the CDUS report as finding that SD had severe stenosis in her right carotid artery. Asked about writing 80% in his pre-op report, he said that "the number might have been biased by what I saw at the time of surgery," which of course was after the fact and could not be used to justify its inclusion in the pre-op report.

95. The CDUS does contain a conclusion of "severe stenosis," but this reference is insufficient support for Respondent's report of "about 80%" stenosis. Dr. Nathanson found no support for Respondent's report of 80% stenosis, and characterized it as a completely false statement.

96. Respondent's report of SD's stenosis as "about 80%" in his preoperative report was inaccurate. It represented a failure to maintain medical records as required by the standard of care for documentation. A finding that the act was also false and/or misleading would imply an element of willful conduct. It was not established to the required standard that Respondent's representations in this regard were deliberately incorrect.

97. It was established that Respondent failed to maintain accurate adequate and accurate patient records for SD.

ALLEGATION 3:
Respondent's documentation of stenosis of "about 80%" without explanation for his disregard for the radiologist's ultrasound findings constituted gross negligence and/or negligence.

98. As previously found, the degree of stenosis is a crucial fact in determining whether a CEA should be performed. Performance of a CEA requires a clear medical indication and documentation of the indication in the medical record. The standard of care however does not require Respondent to explain why he concluded that the degree of stenosis was so much

greater than stated in the radiology reports. Failing to provide such explanation does not constitute gross negligence.

99. It was not established that Respondent's failure to document an explanation for his reporting of stenosis of "about 80%" was below the standard of care and negligent.

ALLEGATION 4:
Respondent's classification of SD as being symptomatic, in that he attributed her near syncopal events to carotid artery stenosis without a full workup or evaluation of the events constituted gross negligence, negligence, and/or incompetence.

100. Respondent's medical record concerning SD contains the inaccurate statement that syncope is symptomatic of carotid artery disease. He also reported in his interview and testified that this is his belief. Respondent's belief is at odds with the other experts and the medical literature. Respondent performed a workup, though he failed to obtain a full workup or evaluation of SD's syncopal events. In his testimony, Dr. Nathanson did not state specifically why the full workup performed by Respondent was inadequate or deficient.

101. It was not established that Respondent's classification of SD as symptomatic due to syncope without first evaluating the syncope was a simple departure from the standard of care and therefore was not negligent. It also does not demonstrate incompetence.

Patient BL

102. On October 7, 2010, Respondent saw BL, then a male age 91, for an evaluation of left internal carotid artery stenosis. He lived independently and was quite physically active. An echocardiogram was taken in 2007, confirming BL had atrial fibrillation. He complained of intermittent syncopal episodes for one to two years. A CDUS taken July 2, 2010, revealed 10% narrowing of the proximal right internal carotid artery and 60% of the left.

Respondent wrote to one of BL's physicians that the CDUS showed "an irregular 60 to 69% stenosis." He also wrote [BL] is neurologically intact. He does describe though syncopal episodes whenever he lifts his left arm over his head. He has a strong radial pulse and no blood pressure discrepancy between the left and right arm and I cannot elicit any vertebral steal syndrome, but he states that this has happened six or seven times this year and with the known carotid artery stenosis, I am recommending that he undergo a carotid endarterectomy.

103. BL chose to have a CEA. In his preoperative history and physical, Respondent reported that the July CDUS showed "50% to 69% left internal carotid artery stenosis. With this being a borderline stenosis, he was followed but since the symptoms are so dramatic and so consistent he was then referred for vascular surgical evaluation and recommended for admission and surgery at this time."

104. Respondent performed a left CEA on October 29, 2010. He noted the same preoperative and postoperative diagnoses: "Symptomatic left internal carotid artery stenosis." The procedure went well and BL was discharged on October 31, 2010.

105. Complainant alleges that Respondent's care of BL constituted gross negligence, negligence and/or incompetence and the failure to maintain adequate and accurate records in the following four respects.

ALLEGATION 1:
Respondent inaccurately and inconsistently reported Patient BL's carotid duplex results, which constitutes inadequate and inaccurate medical records.

106. There was one imaging study on BL, and that stated his degree of stenosis as 60%. Respondent reported the numbers as "50 to 69%" and "60 to 69%", and provided no explanation of the difference between his report and that of the radiologist. The Board's expert did not specifically testify that it was wrong for Respondent to report in terms of a range identified in the ultrasound report or that it was wrong to identify the range and not also include the specific degree of stenosis under the NASCET criteria.

107. It was therefore not established that Respondent failed to maintain adequate and accurate medical records regarding BL.

ALLEGATION 2:
Respondent's performance of a carotid endarterectomy on patient BL was not indicated given that he was 91 years old, had medical comorbidities, had moderate carotid artery stenosis, and was asymptomatic.

108. Dr. Lee opined that it was an extreme departure for Respondent to perform a CEA on BL for the following reasons: he was asymptomatic, as syncope is not a qualifying symptom; the degree of stenosis was not high enough (he testified that the CDUS showed 50% to 69%); he had atrial fibrillation and "a few other morbid conditions"; and he was 91 years old. Dr. Lee opined that "a reasonable physician would have recommended medical management."

109. It was not established that chronological age is a valid reason for not performing a CEA. The standard of care requires the elderly to be evaluated as individuals.

110. It was not established that BL suffered from "multiple comorbidities." The only documented comorbidity was the atrial fibrillation, which was controlled.

111. Dr. Nathanson would "generously describe [Respondent's] approach as unconventional" and specified the type of information he would need prior to performing a CEA. He credited Respondent for discussing BL's cardiac history, but a workup to rule out cardiac issues as a possible source of the syncope should have been performed, instead of proceeding first to "go after the mild stenosis." Dr. Nathanson pointed out that it is "unusual for cerebrovascular disease in the form of an isolated carotid stenosis to be responsible for a syncopal event." He opined that it is not a departure from the standard of care to operate on a 91-year-old, but it is inaccurate to describe BL as symptomatic, and it was below the standard to proceed with a CEA with this amount of information.

112. Respondent noted that BL had been under the care of two other physicians for a long time. He had a heart monitor for his atrial fibrillation and was "fully functioning." He chopped wood, drove a car, and was a good candidate for surgery if it were indicated. His doctors had referred him to Respondent following workups that showed no other reason for the syncopal episodes, following a CDUS that showed 60% stenosis.

113. Dr. Shoor concurred that regardless of the relationship of the syncope to the stenosis, 60% met the criteria for a CEA, and given the velocity measurements, he read the study as showing 65% stenosis. BL's cardiologist and internist were perplexed by the syncope and although it is not a common symptom of carotid artery disease, they sent him for a CDUS. Dr. Shoor opined that BL was not symptomatic, but that he nonetheless was a candidate for a CEA.

114. Dr. Milner opined that Respondent's performance of the CEA was within the standard of care. He opined that BL's syncopal episodes made him symptomatic. But even if he were not, there was sufficient stenosis reported to support a CEA.

115. Dr. Schwartz agreed that ongoing medical evaluation was indicated and that the CEA might have been indicated. He saw no evidence of lack of knowledge and the affirmative evidence of successful therapy accomplished. Medical and cardiology clearances were obtained, which is appropriate for elderly patients. It was reasonable for Respondent to rely on their recommendation that he could undergo the CEA.

116. It was not established to the required legal standard that the performance of a CEA on BL was below the standard of care.

ALLEGATION 3:
Respondent's classification of BL as symptomatic was below the standard of care.

117. Respondent wrote that BL's syncope "has happened six or seven times this year and with the known carotid artery stenosis, I am recommending that he undergo a [CEA]." Respondent has consistently stated that syncope is a symptom of carotid artery disease, and the evidence established that it is not.

118. The evidence established that Respondent's classification of BL as symptomatic was a departure from the standard of care and negligent. It was also incompetent.

ALLEGATION 4:
Respondent's attribution of BL's syncopal events to carotid artery stenosis without obtaining a full workup or evaluation of his syncopal events was below the standard of care.

119. Syncope is not a symptom of carotid artery disease; it does not indicate the presence of that disease and can be caused by multiple physical conditions. By his writing and his oral statements that syncope is such a symptom, it is reasonably inferred that Respondent attributed BL's syncopal events to carotid artery stenosis. Dr. Nathanson opined that BL's syncope should have been subjected to a differential diagnosis analysis prior to the performance

of a CEA. Dr. Nathanson did not, however, testify specifically as to why the workup performed by Respondent was inadequate or deficient.

120. It was not established that Respondent's failure to fully evaluate BL's syncopal events was below the standard of care and negligence.

Other evidence

121. Keith Korver, M.D., is board certified as a general surgeon and as a cardiac thoracic surgeon. He has been licensed as a physician in California since 1982. Dr. Korver is on the staff of 15 hospitals in the Bay Area, although he is predominantly associated with Sutter Santa Rosa, where he started the heart surgery program.

122. Dr. Korver first met Respondent when they were enrolled in residency programs at UCSF. Respondent moved to Michigan to practice, and they became reacquainted when Respondent returned to California to complete a fellowship at Stanford. Dr. Korver was with Northern California Medical Associates (NCMA) in Santa Rosa, a group of approximately 40 physicians. He had a hand in helping to recruit Respondent, and was very pleased when he joined NCMA. With Respondent, NCMA was able to increase carotid artery operations from two to three per year to 70 to 80. As a result, a whole new class of patients could be cared for and new techniques were employed at Sutter Santa Rosa.

123. Respondent started NCMA's vascular surgery program, and Dr. Korver assisted him frequently in the beginning as he wanted him to succeed. He noted that Respondent took on long and difficult cases, such as procedures to save the feet of diabetics, which last five or six hours. They worked together for five to six years, and split call duties 50-50, which he notes was a bit unfair because he is not a vascular surgeon.

Dr. Korver opined that Respondent is an excellent technical surgeon and that his judgment in cardiac surgery is excellent. He based his opinion on the many hours they worked together, assisting each other. Dr. Korver believes that of the approximately 50 surgeons he has observed perform carotid artery procedures, Respondent is in the top two or three; "he is superb."

124. Dr. Korver also opined regarding Respondent's personal interactions with patients. He described him as an excellent person and a great partner, who talks easily with others and is very empathetic with patients. Respondent takes constructive criticism, and they talked about failings and successes in their practices. Dr. Korver believes that Respondent exhibited insight and would engage in self-improvement.

125. Mohammad Hossein Mir-Sepasi, M.D., is board certified as a surgeon and a cardiothoracic surgeon. He obtained his medical degree from Johns Hopkins, then returned to his native Iran to practice. Following the Iranian revolution, he immigrated to the United States, practicing first in Virginia. He moved to California in 1999 and joined a group practice. After approximately two years, Dr. Korver approached him regarding working as an assistant in surgical procedures, and Dr. Mir-Sepasi joined NCMA. He assisted Dr. Korver, Respondent,

and another surgeon, and also assisted with the after care of surgical patients. He is now retired.

Dr. Mir-Sepasi has known Respondent since 2007, when Respondent joined NCMA. He has assisted Respondent in numerous surgeries. Dr. Mir-Sepasi described Respondent as a "very good technical surgeon in vascular surgery." He has shown good clinical judgment in the operating room and interacts well with other members of the surgical team.

LEGAL CONCLUSIONS

1. Unprofessional conduct is grounds for discipline of a physician's certificate pursuant to Business and Professions Code section 2234. Unprofessional conduct includes gross negligence (Bus. & Prof. Code, § 2234, subd. (b)), repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)), incompetence (Bus. & Prof. Code, § 2234, subd. (d)), and the failure to maintain adequate and accurate patient records (Bus. & Prof. Code, § 2266).

2. The evidence established that Respondent was grossly negligent in the treatment of patients SB, RB, and DC. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (b), by reason of the matters set forth in Findings 54 through 59, 73 through 75 and 80 through 82.

3. The evidence established that Respondent committed repeated negligent acts, in that simple departures from the standard of care were found in his treatment of ~~all five~~ three patients. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (c), by reason of the matters set forth in Findings 50 through 53, 68 through 72, 83, 84, ~~98 through 101,~~ and 117 through 120.

4. In the context of professional licensing, "incompetence" means "a lack of knowledge or ability in the discharging of professional obligations. Often, incompetence results from a correctable fault or defect." (*James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109.) The evidence established that Respondent lacked competence in his treatment of SD and BL. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (d), by reason of the matters set forth in Findings ~~100, 101,~~ 117 and 118.

5. The evidence established that Respondent failed to maintain adequate and accurate patent records as regards patients SB, DC, SD, and RB. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2266, by reason of the matters set forth in Findings 60, 85, 86, and 94 through 97.

6. As cause for discipline has been established, it remains to determine the appropriate level of discipline to impose. In making this determination, it is recognized that the purpose of these proceedings is to protect the public, not to punish physicians. Depending upon the violations, the goal is to remediate physicians whenever possible.

Before the Board is an experienced and talented vascular surgeon whose care of five

patients was below the standard of care in different respects. Other than as needed for hearing scheduling purposes and to describe his career history, the timing of the care of the patients vis-à-vis the tremendous strain and tragedy of Respondent's son's cancer was not discussed. But it is striking that this enormous personal problem was ongoing over roughly the same time period as Respondent's care of the five patients in this case. Although this does not excuse or even mitigate the violations, it does supply important context. It is also noted that Complainant recommends license probation.

It is concluded that the public interest will be served and protected, and that Respondent's practice will be assisted, by a five-year term of probation pursuant to the conditions set forth below.

In assessing penalty on remand, the Board has considered the Disciplinary Guidelines, and has determined that the previously assessed discipline remains the appropriate level of discipline, with a minor change made to condition number four, related to a practice monitor. The Board has determined that this level of discipline is the minimum necessary to protect the public and fully rehabilitate Respondent.

ORDER

Physician's and Surgeon's Certificate No. A44147, issued to Respondent James E. O'Dorisio, M.D., is revoked; however, revocation is stayed and Respondent is placed on probation for five years under the following terms and conditions. The Board recognizes that Respondent has been on probation during the course of judicial review, and accordingly, time already served on probation shall be credited toward completion of the probationary period.

1. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine (Program). Respondent shall successfully complete the Program not later than six months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. Determination as to whether Respondent successfully completed the examination or successfully completed the program is solely within Program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program has been completed. If Respondent did not successfully complete the clinical training program, Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

2. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

3. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval

educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

4. Monitoring - Practice

Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name, and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

[redacted] Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

5. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, Respondent's practice setting changes and Respondent is no longer practicing in a setting in compliance with this Decision, Respondent shall notify the Board or its designee within five calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

6. Notification

Within seven days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all

physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities, or insurance carrier.

7. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

8. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

11. Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

12. Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

13. License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's certificate.

14. Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

15. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

16. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws and General Probation Requirements.

17. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

This Decision shall become effective on **December 30, 2016**.

IT IS SO ORDERED: **December 2, 2016**.

Michelle Anne Bholat, M.D., Chair
Panel B
MEDICAL BOARD OF CALIFORNIA

EXHIBIT A

Judgment on Petition for Writ of Administrative Mandate and Order on Petition for Administrative Mandamus

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CALIFORNIA SUPERIOR COURT

CITY AND COUNTY OF SAN FRANCISCO

JAMES EDWARD O'DORISIO, M.D., Petitioner, v. MEDICAL BOARD OF CALIFORNIA, Respondent,	Case No. CPF-15-514600 JMQ [PROPOSED] JUDGMENT ~~GRANTING~~ ON ~~IN PART AND DENYING IN PART~~ PETITION FOR WRIT OF ADMINISTRATIVE MANDATE JMQ

The noticed hearing on the Petition for Writ of Administrative Mandate proceeded and was heard on April 20, 2016 in Department 302 of this Court, the Honorable Joseph M. Quinn presiding. Attorney Michael Firestone of Marvin Firestone, MD, JD & Associates appeared on behalf of Petitioner, James Edward O'Dorisio, M.D. Supervising Deputy Attorney General Jane Zack Simon and Deputy Attorney General Carolyne Evans appeared on behalf of the Respondent, Medical Board of California.

After review and due consideration of the administrative records, the Petition, and all of the moving and the opposing papers filed by the parties, and of the argument presented by counsel for

both parties at the hearing, and with good cause appearing therefor:

The Court ORDERS, ADJUDGES, AND DECREES, that:

1. Petitioner's Petition for Writ of Administrative Mandate is GRANTED IN PART AND DENIED IN PART. The Order on Petition for Administrative Mandamus issued by the Court on May 6, 2016 sets forth the Court's ~~findings and~~ JMQ decision. It is attached hereto and incorporated herein, and shall become the final order of the Court.

2. The matter is remanded to Respondent Medical Board for assessment of penalty on the basis of the findings and determinations set forth in the Court's Order.

3. The parties are to bear their own costs and fees.

DATED: May 25 2016

Honorable Joseph M. Quinn
San Francisco Superior Court

CALIFORNIA SUPERIOR COURT

CITY AND COUNTY OF SAN FRANCISCO

JAMES EDWARD O'DORISIO, M.D., Petitioner, v. MEDICAL BOARD OF CALIFORNIA, Respondent,	Case No. CPF-15-514600 ORDER ON PETITION FOR ADMINISTRATIVE MANDAMUS

On April 29, 2016,[1] this court heard Petitioner James Edward O'Dorisio's Defendants petition for writ of administrative mandamus. O'Dorisio was represented by Michael Firestone and Marvin Firestone, MD – JD & Associates. Respondent Medical Board of California was represented by Carolyne Evans and Jane Zack Simon of the California Attorney General's office.

Upon consideration of the documents and materials filed in support of and in opposition to the motion, the administrative record, the arguments presented, and the record as a whole, IT IS HEREBY ORDERED that the petition for writ of administrative mandate is GRANTED IN PART AND DENIED IN PART.

[1] The court issued a substantive tentative ruling two days before the hearing and both parties contested that tentative.

The matter is before the court for review of a final administrative decision made as the result of a proceeding in which by law a hearing is required to be given, evidence is required to be taken, and discretion in the determination of facts is vested in the respondent board. (See Bus. & Prof. Code, § 2230; see also Gov. Code, § 11500 *et seq.*) Thus, the matter is reviewed by way of petition for administrative and decided by the court sitting without a jury. (See Code Civ. Proc., § 1094.5, subd. (a); Gov. Code, § 11523.) The inquiry extends to the questions whether the respondent has proceeded without, or in excess of, jurisdiction; whether there was a fair trial; and whether there was any prejudicial abuse of discretion. (See Code Civ. Proc., § 1094.5, subd. (b.) Where petitioner claims that the findings are not supported by the evidence, "in cases in which the court is authorized by law to exercise its independent judgment on the evidence, abuse of discretion is established if the court determines that the findings are not supported by the weight of the evidence. In all other cases, abuse of discretion is established if the court determines that the findings are not supported by substantial evidence in the light of the whole record." (Code Civ. Proc., § 1094.5, subd. (c).) Here, the parties agree that the "independent judgment" standard governs. (See Board MPA at p. 6.) "In exercising its independent judgment, a trial court must afford a strong presumption of correctness concerning the administrative findings, and the party challenging the administrative decision bears the burden of convincing the court that the administrative findings are contrary to the weight of the evidence." (*Fukuda v. City of Angels* (1999) 20 Cal.4th 805, 817.)

O'Dorisio has demonstrated that the Board's finding that he was negligent in performing a workup of patients BL and SD is contrary to the weight of the evidence. As to BL, the ALJ found that O'Dorisio failed to workup BL's syncopal events based on Board expert Nathanson's testimony that a full work up was needed. But Nathanson did not testify specifically as to why the workup performed by O'Dorisio was inadequate. (Hearing Tx. 1/7 pp. 54-55.) As to SD, the ALJ relied on Nathanson's testimony that O'Dorisio should have performed a full workup. However, Nathanson did not clearly state that O'Dorisio's workup was inadequate or deficient. (See Hearing Tx. 1/7 p. 51; see also 3/2 pp. 112, 114; 3/3 pp. 119-126.)

O'Dorisio has demonstrated that the ALJ's finding that, as to SD, O'Dorisio negligent

in that he failed to explain his finding of an 80% stenosis or why his analysis differed from the radiologist's analysis is not supported by the weight of the evidence. Neither of the Board's experts clearly testified that failing to provide an explanation is grossly negligent.

O'Dorisio has also demonstrated that the Board's finding that, as to BL, he failed to maintain adequate records in violation of Business and Professions Code section 2266 by failing to accurately report BL's carotid duplex results is contrary to the evidence. O'Dorisio documented a range of narrowing and the narrowing was in the range; the Board's expert did not specifically testify that it was wrong for O'Dorisio to report in terms of a range identified in the ultrasound report or that it was wrong to identify the range and not also include the specific degree of stenosis under the NASCET criteria.

O'Dorisio has not established that the Board's finding that he committed acts of gross negligence in violation of Business and Professions Code section 2234, subdivision (b) ("section 2234(b)") is contrary to the weight of the evidence. The ALJ's finding that O'Dorisio's post-operative care of SB, a patient who suffered post-op strokes and died four days after his CEA, constituted gross negligence in violation section 2234(b) is supported by Board expert Nathanson's testimony that O'Dorisio should have evaluated SB post-op to determine if a neurological event had occurred, he should have obtained an emergent carotid duplex ultrasound ("CDUS"), a non-invasive imaging study that shows the degree of narrowing, and then he should have decided whether to take SB back into surgery (Hearing Tx. 1/7, p. 32.); the ALJ's finding is further supported by O'Dorisio's statement that he usually orders a carotid ultrasound and CT scan to help him make a decision regarding the treatment plan of a patient (AR Ex. 11 p. 32); further, the post-op notes are void of details regarding his post-op care of SB except that they state that herapin was ordered (AR Ex. 5). The ALJ's finding is further supported by O'Dorisio's expert's testimony that the tests are necessary to determine whether re-exploration is needed (Hearing Tx. 3/2 pp. 145-146) and the fact that none was ordered here until many hours later and then only by another physician. O'Dorisio's three experts' testimony that surgery is not needed if the artery is not salvageable (Hearing Tx. 1/6 p. 169, 3/2 p. 82-83; 1/9 p. 115) does not outweigh the above evidence. The ALJ's gross negligence finding as to RB is supported by the Board's experts' testimony that O'Dorisio needed to perform a

complete imaging study of both ends of the vessel given the difficult nature of the procedure. (Hearing Tx. 1/8 p. 82-83; 1/5 p. 74.) O'Dorisio's experts did not provide evidence which showed that given the particular circumstances, O'Dorisio was correct in not obtaining completion imaging of the entire artery or that the Board's experts were incorrect in concluding that end imaging was needed. (Hearing Tx. 1/7 p. 119.) As to DC, the ALJ's finding that O'Dorisio was grossly negligent when he performed a carotid endarterectomy ("CEA"), a dangerous vascular surgical procedure to treat narrowing of the carotid artery when none was indicated is supported by the evidence that O'Dorisio based his decision to operate on inconclusive results from the CUDS and magnetic resonance angiogram ("MRA"), a second non-invasive imaging study (AR Ex. 7 pp. 102, 104-105; Ex. 11 p. 83). O'Dorisio's expert's testimony does not outweigh the above, especially since it was largely based on what O'Dorisio told his experts, not the actual medical record. (Hearing Tx. 3/2 p. 163.)

O'Dorisio has not established that the finding that, in the care of patients SB, RB, and BL, he committed repeated negligent acts in violation of Business and Professions Code section 2234, subdivision (c) ("section 2234(c)") is contrary to the weight of the evidence. As to SB, the ALJ's finding that O'Dorisio deviated from the standard of care is supported by the Board's experts' testimony that the difficult nature of the surgery required O'Dorisio to conduct an imaging completion study (see Hearing Tx. 1/5 p. 48-49; 1/7 p. 26); O'Dorisio's arguments and counter-testimony do not establish that Board's finding is contrary to the weight of the evidence. As to RB, a patient who suffered a post-op stroke and died within days of her CEA, the ALJ's finding is supported by the Board's experts' testimony that D'Orisio's repeated reporting omissions and failure to accurately document stenosis were material departures from the standard of care (Hearing Tx. 1/5 p. 71, 76; 1/7 p. 36.); O'Dorisio's claim that his errors were minor is unavailing. As to BL, the ALJ's finding of negligence in classifying BL as symptomatic is supported by the testimony of Board expert Nathanson, as well as O'Dorisio's own statements that he really considered BL's syncopal incidents to be TIA events (mini strokes) and his circular assertion that the syncopal incidents were symptoms because he called them symptoms. (Hearing Tx. 1/7 pp. 56-57, 103; AR Ex. 9 p. 4, 14, 60; Ex 11 p. 100.)

Nor has O'Dorisio demonstrated that the finding that he was incompetent in characterizing patients BL and SD as symptomatic in violation of Business and Professions Code section 2234, subdivision (d) ("section 2234(d)") is contrary to the weight of the evidence. The ALJ's finding that it was incorrect to classify BL as symptomatic is supported by the testimony of Board expert Nathanson, as well as O'Dorisio's own statements that he really considered BL's syncopal incidents to be TIA events (mini strokes) and his circular assertion that the syncopal incidents were symptoms because he called them symptoms. (Hearing Tx. 1/7 pp. 56-57, 103; AR Ex. 9 pp. 4, 14, 60; Ex 11 p. 100.) The ALJ's finding that O'Dorisio classification of SD as symptomatic due to syncope without an evaluation of the syncope constituted an incompetent diagnosis is supported by the Board's experts' testimony and O'Dorisio's experts' testimony that syncopal events alone are not symptomatic of carotid artery disease. (Hearing Tx. 1/5 p. 100; 1/7 p. 48; 1/9 p. 84, 141; 1/7 p. 138.)

Finally, O'Dorisio has not established that the Board's finding that he violated Business & Professions Code section 2266 by failing to maintain adequate and accurate patient records for SB, RB, DC, and SD, is contrary to the weight of the evidence. As to SB, the ALJ's finding is supported by the Board's witnesses' testimony that filing a report 20 days after an operation falls below the standard of care (Hearing Tx. 1/7 pp. 29, 74 and 78); nor did the report, once filed, show that there was an assistant, it did not identify the tests O'Dorisio had performed on SB, and it did not include the treatment plan (AR Ex. 5 pp 47-48); O'Dorisio's evidence that he prepared a post-op note does not outweigh the Board's evidence on this issue. As to RB, the ALJ's finding on the records issue is supported by the Board's experts' testimony that O'Dorisio's failure to accurately document stenosis (i.e., materially overstating stenosis) was a departure from the standard of care (Hearing Tx. 1/5 p. 71 and 76; 1/7 p. 36); O'Dorisio's unsupported claim that his failures were minor does not outweigh the clear testimony in the record. As to DC, the ALJ's finding on the records issue is supported by the Board's experts' testimony, as well as the testimony of O'Dorisio's expert, Dr. Shoor, that it was not accurate for O'Dorisio to report 60% stenosis based on the MRA and that such report overstated DC's stenosis. (Hearing Tx. 1/5 p 87, 92; 1/7 p. 41, 44; 1/9 p. 75.) As to SD, the ALJ's finding on the records issue is supported by the Board's experts' testimony, as well as O'Dorisio's expert's testimony, that O'Dorisio's material overstatement of the degree of stenosis fell

outside the standard of care and that SD's film was not consistent with an 80% degree of stenosis (Hearing Tx 1/5 pp. 92, 98, 103; 1/7 pp. 49-51); there is no substantial evidence to the contrary.

Where a challenge to one or more finding is upheld, courts will ordinarily remand the matter to the agency to reassess the penalty on the basis of those findings that were upheld. (See *Bonham v. McConnell* (1955) 45 Cal.2d 304; *Zink v. City of Sausalito* (1977) 70 Cal.App.3d 662, 665.) The court has upheld some, but not all, of O'Dorisio's challenges. The court cannot find that the findings that were not upheld were inconsequential as a matter of law for purposes of the Board's corrective action. Thus, the court remands the matter to the Board for assessment of the corrective action on the basis of the findings that have been upheld.

IT IS SO ORDERED.

DATED: May 5, 2016

Honorable Joseph M. Quinn
San Francisco Superior Court

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against:	)	
JAMES EDWARD O'DORISIO, M.D. Physician's and Surgeon's Certificate No. A 44147	)	Case No. 12-2011-217415
Petitioner	)	

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Michael A. Firestone, MBA, JD., attorney for James Edward O'Dorisio, M.D., for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on November 2, 2015.

IT IS SO ORDERED: October 29, 2015

By: Dev Gnanadev MD

Dev Gnanadev, M.D., Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against:	)	
JAMES EDWARD O'DORISIO, M.D.	)	
	)	MBC No. 12-2011-217415
Physician's and Surgeon's Certificate No. A 44147	)	
Petitioner	)	

ORDER GRANTING EXTENSION OF STAY

The Petitioner having recently filed a Petition for Reconsideration, the stay of execution heretofore granted in this matter is hereby extended pursuant to Government Code section 11521 (a), until November 2, 2015.

This stay is extended for the purpose of allowing the Board to review the Petition for Reconsideration.

DATED: October 20, 2015

Kimberly Kirchmeyer
Executive Director
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against:	)	
	)	MBC No. 12-2011-217415
JAMES EDWARD O'DORISIO, M.D.	)	
Physician's and Surgeon's Certificate No. A 44147	)	**ORDER GRANTING STAY**
	)	(Government Code Section 11521)
Respondent	)	

Michael A. Firestone, MBA, JD. on behalf of respondent, James Edward O'Dorisio, M.D. has filed a Request for Stay of execution of the Decision in this matter with an effective date of September 23, 2015.

Execution is stayed until October 23, 2015.

This stay is granted solely for the purpose of allowing the Respondent to file a Petition for Reconsideration.

DATED: September 15, 2015.

Kimberly Kirchmeyer
Executive Director
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against:	)	
JAMES EDWARD O'DORISIO, M.D.	)	**Case No. 12-2011-217415**
Physician's and Surgeon's Certificate No. A 44147	)	
Respondent	)	

DECISION AND ORDER

The attached Proposed Decision is hereby amended, pursuant to Government Code section 11517(c)(2)(c) to correct technical or minor changes that do not affect the factual or legal basis of the proposed decision. The proposed decision is amended as follows:

The wording "In the Matter of the Accusation Against" is stricken and replaced with "In the Matter of the Second Amended Accusation Against"

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on September 23, 2015.

IT IS SO ORDERED August 24, 2015.

MEDICAL BOARD OF CALIFORNIA

By: Dev Gnanadev MD
Dev Gnanadev, M.D., Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
JAMES E. O'DORISIO, M.D.	Case No. 12-2011-217415
Physician's and Surgeon's Certificate No. A44147	OAH No. 2014080414
Respondent.	

PROPOSED DECISION

Administrative Law Judge Mary-Margaret Anderson, Office of Administrative Hearings, State of California, heard this matter on January 5 through 9, and March 2 through 4, 2015, in Oakland, California.

Jane Zack Simon, Supervising Deputy Attorney General, and Carolyne Evans, Deputy Attorney General, represented Complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

Marvin H. Firestone, M.D., Attorney at Law, and Michael A. Firestone, Attorney at Law, represented Respondent James O'Dorisio, M.D., who was present.

The record remained open to allow the parties to file written closing argument. The briefs were timely filed and marked for identification as follows: Complainant's Closing Argument, Exhibit 20; Respondent's Closing Argument, Exhibit DD; and Complainant's Reply, Exhibit 21.

The record initially closed on May 26, 2015, following receipt of Complainant's reply brief.

The record was reopened on July 8, 2015. A conference call was held with counsel to discuss the possibility that a page of an exhibit may have been missing. Respondent's closing brief referenced page 00060 of Exhibit 6, and it could not be located in the record. Counsel were instructed to meet and confer on the issue of page 00060.

On July 15, 2015, Respondent filed a request that page 00060 and newly found office notes be added to the record. On July 16, 2015, Complainant filed an opposition to the request.

Respondent's request and Complainant's opposition were marked for identification in the record as Exhibit EE and Exhibit 22, respectively.

The record closed on July 16, 2015.

EVIDENTIARY RULINGS

RB's operative report, page one- page 00060

1. Exhibit 6 contains portions of patient RB's medical records. Bates-stamped page 00060 is a page from her certified medical records that was included in discovery, but was not originally made a part of Exhibit 6. Respondent, however, referenced page 00060 in his closing brief. The record was reopened and the parties asked to respond to these facts.

2. Page 00060 is the first of two pages of Respondent's operative report following his performance on January 31, 2011, of a right carotid endarterectomy on RB. Respondent requests that page 00060 be included in the administrative record as part of Exhibit 6.

Respondent also requests that uncertified records, described as "Office Notes from 1/28/10, 7/29/10, and 8/26/10" be added to the record. These documents were not provided to Complainant in discovery, are not authenticated, and are reported to have been recently found.

Complainant objects to the admission of any of the documents.

3. Respondent's request is granted as to the admission of page 00060 as part of Exhibit 6. The merits of a complete administrative record outweigh Complainant's concerns that the late admission prevents specific comment by Complainant's expert and cross-examination of Respondent regarding the document. There is no need for expert analysis of page 00060.

4. Respondent's request is denied as to the admission of the "Office Notes." Good cause does not exist to augment the record with these new documents. To do so without prejudice to Complainant would require re-convening the administrative hearing. Considering all of the relevant facts and argument, it is concluded that the probative value of the additional evidence is substantially outweighed by the undue consumption of time that would be necessary. (Gov. Code, § 11513, subd. (f).)

Admission of Exhibit 19

5. At the last hearing session, Complainant offered a declaration from Kira Parisi (marked as Exhibit 19) as rebuttal evidence. Respondent objected, and a ruling was deferred pending the receipt of argument in the closing briefs.

6. Exhibit 19 was offered to rebut Respondent's testimony that he reviewed imaging studies as to patient SD. It is a declaration from an employee of a radiology laboratory, who asserts that she is "familiar with the record keeping system . . . and if called as a witness, could competently testify" to such matters. She declared that, among other things, she searched the laboratory's records and did not find a request for study images for RB from Respondent or anyone else.

7. Exhibit 19 is a hearsay declaration offered for its truth. Government Code section 11513, subdivision (d), provides that hearsay is admissible to supplement or explain other evidence, but if objected to, is insufficient to support a factual finding unless a hearsay exception applies. Respondent objected to Exhibit 19.

8. Complainant asserts Exhibit 19 qualifies for an exception under Evidence Code section 1272 as evidence of the absence of a business record. It was not established that Exhibit 19 qualifies for admission under Evidence Code section 1272. (See *People v. Dickinson* (1976) 59 Cal.App.3d 314, 318.) It does not meet the criteria for any hearsay exception, and is therefore not admitted as direct evidence.

9. Exhibit 19 is admitted as administrative hearsay. (Gov. Code, § 11513, subd. (d).)

FACTUAL FINDINGS

1. Complainant Kimberly Kirchmeyer issued the Accusation in her official capacity as Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On October 26, 1987, the Board issued Physician's and Surgeon's Certificate No. A44147 to James E. O'Dorisio, M.D. (Respondent). As of November 14, 2014, it was scheduled to expire on April 30, 2015, unless renewed. Respondent is a vascular surgeon.

3. The Accusation alleges that Respondent committed unprofessional conduct (gross negligence, negligence, incompetence, and/or failed to maintain adequate and accurate medical records) in the treatment of five patients. As to two patients, he was alleged to have made false and misleading statements in the medical record. Respondent filed a notice of defense and this hearing followed.

4. The standard of proof applied in making the factual findings is clear and convincing evidence to a reasonable certainty.

Respondent's background

5. Respondent received a bachelor's of science degree from the University of Denver with a double major in chemistry and biology in 1978 and graduated from the

University of Colorado Medical School in 1982. While at Colorado, he was influenced by Robert B. Rutherford, M.D., Chief of Vascular Surgery and author of Vascular Surgery, the preeminent textbook. He chose residency programs in accordance with his early interest in vascular surgery: Baylor College of Medicine and Cornell University Medical College. At Baylor, Michael DeBakey, M.D., considered the father of cardiovascular surgery and the inventor of the carotid endarterectomy surgical procedure, was head of the program. Respondent was Dr. DeBakey's personal resident twice.

In 1989, Respondent completed a residency in cardiothoracic surgery at the University of California, San Francisco, Medical School (UCSF). He then moved to Michigan, where he was in private practice until 2005. In the meantime, in 2000, he returned to California for a fellowship in endovascular surgery at Stanford.

In 2005, Respondent moved to California and worked in the Kaiser Permanente system for one year. From 2007 until 2014, he was in private practice with Northern California Medical Associates, Inc., in Santa Rosa. He left the group in May 2014.

6. Respondent estimates that he has performed nearly 10,000 surgical procedures in his career, including at least 1,000 carotid endarterectomy (CEA) surgical procedures. Since moving to California, he believes he has performed over 200 CEA's. One of these patients died, one died following a "re-do," and one patient had a stroke. Respondent testified that he has never been sued for malpractice, but in his Board interview said there was a lawsuit in Michigan in approximately 2002 that was settled for $75,000.

7. Respondent is not board certified. On one occasion he did not pass the written general surgery exam, but subsequent exams were not taken because of family obligations. Respondent is, however, highly trained as a cardiac and vascular surgeon, and has over 25 years of experience.

8. Respondent has had special training in reading carotid ultrasound images. In the mid-1990's he obtained national certification for a laboratory in his community in Michigan. He was medical director of the laboratory, read results there, and continued to do so for non-invasive studies after moving to California.

9. In 2008, Respondent's son, age 16, was diagnosed with a rare form of cancer that had already metastasized. During his initial treatments, Respondent did not change his practice despite supervising his son's care and spending a great deal of time with him. There was some improvement, but he experienced a recurrence in 2010. At that point Respondent changed his schedule to accommodate assisting his son with treatments, including by traveling with him to other cities, sometimes out of state. Respondent reduced his practice of medicine after that date. He also formed a company to conduct research on new treatments for cancer.

10. Respondent's care of the five patients that are the subjects of this case occurred at Sutter Hospital in Santa Rosa. In 2011, concerns were raised by the quality department about complications in CEA's performed by Respondent. Reviews of the cases were undertaken, and

restrictions imposed including that Respondent consult with a neurologist before proceeding with surgery. Subsequently, the Medical Executive Committee voted to revoke his hospital privileges. Respondent appealed. Following presentations by both sides, a settlement was offered through a mediation process, and Respondent accepted it. As part of the settlement, Respondent relinquished his privileges at Sutter Santa Rosa.

11. Respondent has hospital privileges at Ukiah Valley Medical Center, with no restrictions. As of the date he testified, he was keeping close control on his hours, to be available for his son.[1] He was working approximately nine to five, unusual for a surgeon, and performing every procedure except cardiac surgery. Respondent was also working at the hospital's wound center, and was set to become the director the following month.

Expert opinion evidence

12. Including Respondent, six physicians, all experts in vascular surgery, opined regarding the standard of care for the performance of CEA procedures and Respondent's care of the five patients. Two of the experts authored written reports.

EUGENE LEE, M.D.

13. Eugene Lee, M.D., is a California licensed physician and surgeon, and is board certified in vascular surgery. He received his medical degree from Tufts University in 1994, and completed a general surgery residency at the University of Minnesota in 2002 and a fellowship in vascular surgery at Stanford Medical School in 2004. Dr. Lee is the Chief of Vascular and Endovascular Surgery at the Sacramento Veterans Affairs Medical Center, and he performs CEA's at that facility two to three times weekly. He is also an Associate Professor in the Department of Surgery at the University of California at Davis Medical Center. Dr. Lee is an active member of the Society of Vascular Surgery and many other professional organizations. He is extensively published in peer-reviewed journals, and has authored two book chapters. Dr. Lee testified at hearing and also authored a written report.

DANIEL NATHANSON, M.D.

14. Daniel Nathanson, M.D., is a California licensed physician and surgeon, and is board certified in vascular surgery. He received his medical degree from Pennsylvania State University College of Medicine in 1997, and completed general surgical residencies at both St. Vincent's Hospital and Medical Center in New York (2000) and Brigham and Women's Hospital in Boston (2004). Dr. Nathanson completed a fellowship in vascular surgery at UCSF in 2007. He is the Director of the Endovascular Surgery Program at California Pacific Medical Center. He is also a Clinical Associate Professor at UCSF, where he teaches vascular surgery to general surgery residents.

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[1] Respondent's son passed away on May 15, 2015.

LEWIS SCHWARTZ, M.D.

15. Lewis Schwartz, M.D., is licensed as a physician in Illinois, Michigan, Massachusetts, and North Carolina, and is board certified in general surgery and vascular surgery. He was licensed in California at one time, but has not practiced here. He received his medical degree from the University of Chicago Pritzker Medical School in 1987. He completed a surgical residency at Duke University Medical Center in 1994, and a fellowship in vascular surgery at Brigham and Women's Hospital in Boston in 1995. He has taught surgery at the University of Chicago in one position or another since approximately 2002. His current title is Clinical Associate Professor. He currently performs surgery one week each month. Dr. Schwartz is a distinguished fellow of the Society of Vascular Surgery and is on the editorial board of the Journal of Vascular Surgery. He is extensively published.

Dr. Schwartz met Respondent approximately 20 years ago when Respondent was practicing cardiac and vascular surgery in Michigan. In addition to reviewing the patient records, expert reports and other documents in evidence, he discussed the case with Respondent and was present for most of the hearing. He testified and authored a written report. Dr. Schwartz is of the opinion that Respondent is a talented surgeon.

PERRY M. SHOOR, M.D.

16. Perry M. Shoor, M.D., is a California licensed physician and surgeon and is board certified in vascular surgery. He received his medical degree from The Chicago Medical School (now the University of Health Sciences) in 1971. He completed a surgical residency followed by a fellowship at University of California, San Diego, in 1978. Dr. Shoor completed a fellowship in peripheral vascular surgery at Stanford in 1979. He practiced as a vascular surgeon from 1979 until 2010, when a hand injury ended his surgical practice. Dr. Shoor estimates he has performed between 1,100 and 1,200 CEA's in his career. He is a member of the Society of Vascular Surgery, and is a published author of articles and book chapters.

ROSS MILNER, M.D.

17. Ross Milner, M.D., is licensed as a physician in Illinois. He received his medical degree from the University of Pennsylvania in 1994, and completed a surgical residency and a fellowship in vascular and endovascular surgery at the same institution. Dr. Milner was the program director for the vascular surgery fellowship program at Emory University for seven years, then became chief of vascular surgery at Loyola University Medical Center in Chicago. Currently, he is a full professor at the University of Chicago Medical Center, where he also practices surgery between 60 and 70 hours per week. Dr. Milner is extensively published, with approximately 80 peer-reviewed articles and over 20 textbook chapters. He estimates he has performed over 500 CEA's in his career, with the most recent occurring in February 2015.

ADDITIONAL EXPERT EVIDENCE

18. In addition to the expert testimonial evidence, the factual findings are informed by *Rutherford's Vascular Surgery,* seventh edition, chapter 95, "Carotid Artery Disease: Endarterectomy" (Rutherford's). It was undisputed that Rutherford's is the authoritative textbook in the specialty. In addition, information from peer-reviewed journal articles in evidence, as explained or referenced by the expert witnesses, also informed certain factual findings. These include guidelines issued by the Society for Vascular Surgery issued in 2008 (SVS Guidelines).

Analysis of expert opinions

19. Although the experts' opinions varied as to the standard of care to some extent, they did not differ in many respects. All of the experts offered valuable information and rendered opinions that were persuasive to various degrees. As no expert was entirely persuasive or not persuasive, a general finding to that effect is not made. Each expert's opinion was carefully considered in making each finding, whether or not the particular expert's opinion is reported in the factual finding.

Overview of procedures to treat blockages of the carotid artery

20. Vascular surgeons treat carotid artery disease. The carotid artery is located in the neck, between the ear and lower neck. It provides oxygenated blood from the heart to the brain. There are three main segments of the carotid artery: the common carotid artery (CCA), the internal carotid artery (ICA), and the external carotid artery (ECA). The carotid bulb is the point where the CCA bifurcates into two branches and becomes wider.

21. This matter primarily involves Respondent's performance of CEA's, which treat stenosis (narrowing or constricting of the diameter) of the carotid artery. Cholesterol plaque (also called atherosclerosis or blockage) can form in the carotid artery and the resulting stenosis can inhibit or block blood flow. The plaque itself, or blood clots attached to it, can break off and travel to the brain through the ICA, and cause a stroke.

22. There are two surgical approaches used to treat patients with stenosis. One is carotid stenting. A balloon is inflated within the artery, expanding a stent, which compacts the plaque against the wall of the artery, preventing it from breaking off. The other is the CEA.

23. To perform a standard CEA, the surgeon opens the carotid artery and removes plaque, generally following a longitudinal incision. Opening the artery cross-wise is called the eversion technique. Whichever method is used, the artery is closed with sutures in the arterial wall or with a patch.

24. CEA's are dangerous surgeries. The risks include bleeding, stroke and death. They should only be performed for patients with high levels of stenosis and where it is clear that

the risk of stroke will be reduced; in other words, when the potential benefit outweighs the risk of surgery.

25. Different types of imaging studies may be conducted to show the degree of stenosis, and each have risks, benefits, and costs. They also report the degree of stenosis in different ways. The carotid duplex ultrasound (CDUS) is considered accurate and reliable, and is non-invasive. It is a duplex study because it reports both a picture of the artery, which can reveal the character of the plaque, and the degree of velocity, which gauges the amount of stenosis by how fast the blood is flowing through the artery. An instrument uses ultrahigh-frequency sound waves to penetrate the skin, and applies the Doppler principle to estimate the velocity of blood flowing through the artery. The higher the velocity is, the higher the degree of stenosis. The velocity is reported, and a color-coded two-dimensional image of the artery is provided, which shows the shape and size of the plaque. The colors represent blood flow direction. The estimate of the amount of stenosis is given in a range, such as 60 to 70%. In most cases, a CDUS is the only imaging study needed to evaluate a patient for a CEA.

The magnetic resonance angiogram (MRA), a study using magnetic resonance imaging, is also noninvasive, but may overestimate the degree of stenosis. An MRA gauges the size of the plaque and the lumen (the cavity of the vessel) by how fast protons are spinning inside the cells.

Other types of studies are quite invasive. A computed tomographic angiogram (CTA), also called a CAT scan with angiography, is more expensive, and requires the infusion of a chemical dye. And a conventional angiogram requires puncturing a femoral artery in the groin to thread a catheter to the base of the neck. Contrast dye is injected into selected arteries and x-rays show the location and extent of blockage.

26. Radiologists interpret imaging studies and issue written reports of their findings. Other medical specialists can also interpret imaging studies, depending upon their training and experience. Vascular surgeons generally are so trained, and can have valid opinions that can differ from the radiologist's interpretation.

27. A completion study is a test performed after the CEA procedure is completed. It is an objective test and can consist of any of the studies discussed above, performed in the operating room, or later when and if the patient exhibits neurological defects. A continuous wave Doppler (CWD) can be used as a completion study, but it does not result in an image that can be studied.

Indications for CEA for asymptomatic patients

28. The goal of a CEA is to reduce the risk of stroke. The main risk factors for strokes caused by carotid atherosclerotic disease are the presence of related symptoms and the degree of carotid stenosis. Studies have been conducted and guidelines issued by professional societies to help determine what degree of stenosis warrants the risk of a CEA procedure. The degree is very important in making that decision, but the relevance of the degree varies

depending upon other factors, including whether the patient has symptoms that are signs of carotid artery disease; in other words, whether the patient is symptomatic or asymptomatic. It is a somewhat controversial and evolving area of study as to what degree of stenosis warrants the invasive procedure of a CEA, and what does not, particularly in an asymptomatic patient.

29. As regards symptomatic patients, the consensus is that a CEA is beneficial where the stenosis is severe. For asymptomatic patients, the benefits of CEA are less clear and the degree of stenosis that establishes benefit is not as well established. Nonetheless, Rutherford's and the SVS Guidelines are consistent. They assert that significant benefit has been established for asymptomatic patients with stenosis equal to or greater than 60%. Each of the retained experts in this matter agreed, although Dr. Nathanson identified it somewhat differently as 60 to 70%. And in his interview, Respondent identified the degree of stenosis as 70% or greater, but added that "there are certainly very large studies that use 60% asymptomatic as their cutoff."

Dr. Lee, however, introduced a qualifier to the guidelines because of his understanding that the studies underlying the conclusion used angiographic results to report the degree of stenosis. He asserts that an angiogram result of 60% correlates with 80% in a CDUS, and that therefore a CDUS of equal to or greater than 80% is needed before a CEA can be recommended for an asymptomatic patient. He was adamant on this point, stating that it is well understood by vascular surgeons, and that there is no confusion regarding this matter. Dr. Lee's references to the literature to reinforce his opinion, however, were not successful, and Dr. Schwartz was equally adamant that it was incorrect. Dr. Schwartz opined that there is no expectation that an ultrasound that reads 80% is actually 60%; that the expectation is that the correlation is one-to-one. Dr. Lee was not persuasive on this point.

30. According to Rutherford's and other sources, there is no consensus on which imaging modality is the most accurate for determining the degree of stenosis. There are studies that report some evidence for better accuracy from each of the CDUS, MRA, and the CTA modalities. There is evidence that the MRA overestimates degree, which makes it harder to differentiate more moderate from severe stenosis. On the other hand, as stated above, the CDUS is now the most commonly used imaging study when evaluating a patient for a CEA, and procedures are commonly done following the CDUS alone.

31. There are instances, however, when one study is insufficient. On the subject of when there is a need for additional imaging testing, Rutherford's concludes:

> Clearly, if the patient is found to have an intermediate stenosis and is asymptomatic, one should perform at least another noninvasive test to confirm this finding before recommending CEA. If there is discordance between these studies, one should either obtain a third non-invasive test or resort to angiography. . . .

The SVS Guidelines concur. Specifically as to the CDUS, they recommend additional imaging studies before surgical intervention where the degree is reported in the intermediate range of 50% to 69%.

32. Regardless of the imaging study used and the degree of stenosis reported, the decision to perform a CEA is made based upon all of the available data. This includes information specific to the individual patient, such as is gleaned by history and physical examination and other tests, other conditions the patient may have, the patient's personal preferences, and the surgeon's judgment based on training and experience. In other words, the decision is not properly made based upon the results of an imaging study standing alone.

Patient SB

33. Patient SB,[2] an 80-year-old male, first presented to Respondent on March 4, 2010, for a consultation. He had a previous history of stoke and left CEA eight years prior. SB did not report any transient ischemic attacks (TIA), syncope (fainting), or new weaknesses. SB had residual weakness in his right arm, but otherwise functioned well.

34. A CDUS on February 11, 2010, revealed 50% to 69% stenosis of the right internal carotid artery and 80% to 90% restenosis of the left internal carotid artery, with peak velocities over 600 cm/sec. Respondent noted[3] that he discussed the option of carotid stenting with SB, but that SB wanted to have a second CEA. Respondent did not obtain any additional imaging studies.

35. On March 19, 2010, Respondent performed a "re-do" left CEA on SB. He noted that it was a long and difficult operation. Instead of plaque, which can be removed, Respondent found neointimal hyperplasia, which cannot. A classic CEA was therefore not performed; instead, Respondent widened the artery, using a patch angioplasty.

36. There is no indication in SB's medical record that an assistant was present for the surgery.

37. Respondent did not obtain a completion study following the procedure.

38. At 10:30 p.m., Respondent made the first post-operative note, containing status information such as that the procedure was a left CEA re-do with a Dacron patch repair with no complications. He also noted that SB's right arm is slightly weaker than his left from an old stroke, and that "this is his base line." At 11:30 p.m., approximately one hour after the surgery, Respondent noted that SB: was slow to wake in the recovery room; had occasional left arm and leg movement but the right side was quiet; that he was not yet responding to verbal commands; and that he had an interrupted breathing pattern. The experts agree that these observations were consistent with a stroke. Respondent testified that he consulted with a neurologist and intensivist (the physician assigned to the intensive care unit, or ICU) in the early morning hours, and it was decided that SB would remain in the ICU

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[2] Patients are referred to by numbers to protect privacy.

[3] "Noted" means Respondent entered the information in a patient's medical record.

and receive intravenous heparin (a blood thinner) with the hope of dissolving the clot that was blocking the flow to the brain and preventing further clot formation. Respondent, however, did not document a treatment plan, and made no further chart notes until the following day.

39. Another physician ordered a CT imaging study at approximately 4:35 a.m. the next morning, which showed an occluded left carotid artery.

40. A CDUS taken March 20, 2010, showed complete occlusion of the left common and internal carotid arteries. A CT scan of SB's head on March 21, 2010 showed a massive stroke. SB died on March 23, 2010.

41. Respondent's operative report states that it was dictated on April 7, 2010.

42. Complainant alleges that Respondent's care of SB constituted gross negligence, negligence and/or incompetence and the failure to maintain adequate and accurate records in the following five respects.

ALLEGATION 1:
Preoperatively, Respondent did not obtain appropriate imaging studies, such as a CT angiogram.

43. Dr. Lee opined that Respondent's failure to obtain another imaging study, specifically a neck and chest CT angiography, prior to performing the CEA was below the standard of care. That test would have revealed the extent of internal carotid artery disease and arch anatomy, which informs the decision of which procedure, if any, should be performed. As the lesion was on the neck, in this instance the test would not have contributed very much relevant information, but should have been performed. Dr. Nathanson concurred with this opinion, reasoning that a CTA helps to show the location of the disease, and helps in the decision of whether the patient is a candidate for a stent. He cannot "think of anytime I did a re-do without additional imaging studies." In addition, he believes that such studies assist when discussing the options with the patient.

44. Respondent, and Drs. Schwartz, Milner and Shoor, disagree. They concur that the CDUS provides sufficient information to proceed with a CEA, even a re-do. An angiogram would be indicated if a stent was planned, but was not necessary in this case. It was clear that there was a very high degree of stenosis and that SB preferred a CEA over other procedures. Patient SB had been referred from another physician, who had done a thorough work-up.

45. The CDUS result was 80 to 90% restenosis in the left carotid; it was not disputed that a CEA was warranted. As regards additional imaging studies, the literature recommends such be done where the result shows moderate stenosis, not severe. It is concluded that obtaining an additional imaging study prior to the CEA was at the surgeon's discretion.

46. It was not proven to the required standard that the failure to obtain additional imaging studies prior to performing a CEA in the case of SB was below the standard of care.

ALLEGATION 2:
Respondent did not provide proper counseling to SB prior to surgery.

47. Dr. Lee opined that the lack of a second pre-surgical imaging study meant that SB did not have sufficient counseling prior to surgery.

48. Respondent's notes dated March 4, 2010 state: "Option of current stenting discussed with the patient and he has no interest in carotid stenting and would like to proceed with carotid surgery. All risks and benefits were discussed. Will plan for this." Respondent testified that he discussed the surgical options and the risks and benefits of a re-do CEA, as well as stenting, with SB. Respondent could have performed either procedure. SB, however, was strongly opposed to stenting, because of stories from friends and family members who had bad outcomes.

49. It was not proven that Respondent's pre-surgical counseling of SB was below the standard of care.

ALLEGATION 3:
Intraoperatively, Respondent failed to obtain and/or document a completion imaging study in the operating room at the conclusion of the operation.

50. Dr. Lee asserted that an imaging study should have been obtained given the difficulty of the procedure, and SB's history and condition. Drs. Lee and Nathanson opined that Respondent's failure was a departure from the standard of care.

51. Respondent explained that he always uses continuous wave Doppler, which is a type of completion study. He uses the Doppler in conjunction with a "look, listen and feel" method to assess the patient's condition. There is no image to look at, but his trained ear recognizes the appropriate sounds and can assess the patient.

52. It is recognized that a continuous wave Doppler is a type of completion study, but it is not an imaging study. SB's surgery, the second attempt to clear stenosis, was described by Respondent as one of his most difficult in five years. Although the decision to proceed with surgery was supportable, the risk of stroke was great. Technical problems with the procedure can increase the risk of stroke. It was incumbent upon Respondent to obtain the information revealed by an imaging study before concluding the procedure.

53. It was proven that Respondent's failure to obtain and document a completion imaging study of SB was below the standard of care.

ALLEGATION 4:

Post-operatively, when it was observed that SB had neurologic deficits, Respondent failed to properly evaluate, diagnose, or exclude a technical problem. The standard of care is to manage the problem immediately, with either urgent carotid duplex study or re-exploration of the carotid artery. Neither was done.

54. A post-operative stroke is almost always caused by a technical error during surgery. An imaging study post-procedure might have identified issues that needed correction, but none was done immediately, or even after SB evidenced neurological problems at 11:30 p.m. Once the deficit was noticed, Respondent might have returned SB to the operating room, re-sectioned the segment of diseased artery and placed a graft. Dr. Lee opined that SB should have been evaluated prior to leaving the operating room, and certainly immediately following the observation of neurological deficits at approximately 11:30 p.m.

55. There is scant evidence in the medical record of Respondent's attention to SB post-operatively. Respondent does not recall if he remained at the hospital. He testified that he remained involved and "would have" discussed the case with the intensivist. In sum, Respondent asserts that he and the intensivist discussed the case, he decided not to go back to the operating room, and decided that SB would remain in the recovery room and receive heparin. None of this is documented, except the fact that heparin was given. The records show that another physician ordered a CDUS at 4:30 a.m. the following morning, five hours after the deficits were observed.

56. Respondent's position that his care met the standard is belied by a statement in his interview. He said that he "would typically order the two tests that were ordered to try to help me make that decision. That is a carotid ultrasound and CT scan." In fact, it appears that the experts agreed that Respondent did not have sufficient information to determine that it was futile to return SB to the operating room at the time he asserts that he made that decision.

57. Dr. Schwartz's opinion that the post-operative treatment of SB was within the standard of care was based upon studies showing a lack of benefit from re-exploration following observation of a new deficit. He appears to miss the point. The issue is Respondent's post-operative management of the patient, including during the time period before the stroke was confirmed. And Respondent's argument that the record supports a conclusion that the stroke occurred perioperatively is not supported by the evidence.

58. Dr. Nathanson succinctly described the standard of care when he described what he would have done if SB was his patient: that he would sit bedside and establish whether or not a neurologic event had occurred, obtain an emergent CDUS, and either take the patient back to the operating room, or decide not to do so.

59. The evidence established that Respondent's post-operative care of SB constituted an extreme departure from the standard of care and gross negligence.

ALLEGATION 5:
Respondent's failure to dictate his operative report in a timely manner, his failure to document the presence of an assistant during the procedure, his failure to document a completion study (if one was done), and his failure to document a treatment plan when neurological deficits were observed constitutes unprofessional conduct and the failure to maintain adequate and accurate medical records.

60. The standard of practice requires physicians to make and maintain accurate and sufficient medical records for their patients. A 20-day delay in dictating or writing an operative report violates this standard. Timeliness, which generally assists in accuracy, is particularly important in the case of a patient who has undergone a complex and difficult surgical procedure, and who will then be followed by other health care professionals in the crucial time immediately following the surgery. Respondent argues that dictation of reports sometimes does not get transcribed, and that he has had to re-dictate reports in the past, although there is no evidence that this occurred in SB's case. He also argues that when something is always done, for example, having an assistant for the procedure, it is not necessary to be documented. This assertion is not accepted.

In the report he eventually prepared, Respondent failed to document the completion studies he asserts he performed, and the treatment plan he decided upon with the intensivist. He failed to mention that he had an assistant, and who the assistant was. (It is noted that in the case of patients RB and SD, the same operative report format was used by Respondent, and there is a category identified as "ASSISTANT" followed by the name of a physician.) His notes immediately following the surgery were cursory.

61. It was established that Respondent failed to maintain adequate and accurate records for SB.

Patient RB

62. Patient RB, then a 66-year-old woman, saw Respondent for a consultation in 2010. She had a prior history of stroke. On August 13, 2010, Respondent performed a left CEA. On October 5, 2010, he performed an abdominal aortic and bilateral iliac balloon angioplasty. RB was a continuing patient of Respondent's and he asserts he knew her well.

63. On December 16, 2010, RB saw Respondent for a follow-up examination and a CDUS taken December 10 was discussed. The report showed 70 to 80% stenosis in RB's right internal carotid artery. Respondent wrote RB's physician that the report showed "progressive stenosis of the right side, now approaching 80%." She was asymptomatic. He recommended a right CEA and RB agreed.

64. Respondent performed a right CEA on January 31 through February 1, 2011. In one operative report, in the Indication section, Respondent wrote that RB had

multiple cardiovascular problems, including bilateral carotid disease. She has had a previous stroke that involved weakness of her left arm and leg. Symptoms mostly had resolved over the years. She more recently had a left carotid endarterectomy for severe internal carotid artery stenosis and *now is brought in for elective right carotid endarterectomy for a greater than 80% right internal carotid artery stenosis.* [Emphasis added.]

65. The procedure went well, but post-operatively RB evidenced a neurologic deficit. A CDUS was obtained that showed compromised flow. Respondent undertook a re-exploration that was very difficult. He found RB's artery to be "friable," which means very fragile, thin, and/or falling apart. He used a saphenous vein from her left ankle to replace a segment of the artery and inserted a self-expanding stent.

Respondent did not obtain a completion study after the procedure.

In another operative report in the Indications section, Respondent wrote that RB had experienced a good postoperative result from the left CEA, and that "She also now has a progressing, now about 80%, right carotid stenosis."

66. On February 2, 2011, RB died following a stroke. In a death summary, Respondent wrote that RB had "progressive stenosis now of the right side . . . ."

67. Complainant alleges that Respondent's care of RB constituted gross negligence, negligence and/or incompetence and the failure to maintain adequate and accurate records in the following three respects.

ALLEGATION 1:
Respondent inaccurately and inconsistently reported patient RB's carotid duplex results, including the degree of stenosis.

68. The consult letter Respondent wrote on December 16, 2010, states: "Her follow-up carotid ultrasound . . . also shows, though, progressive stenosis of the right side, now approaching 80%. [RB] is asymptomatic but because of her progressive stenosis on the right side we have discussed elective right carotid endarterectomy . . . ."[4] In one operative report, Respondent wrote that RB had "a greater than 80% right . . . stenosis," and in another that she had "a progressing, now about 80%, right carotid stenosis." The death report states that "she had progressive stenosis now of the right side." In his report to the Sutter Medical Executive Committee, Respondent wrote that RB had a right CEA "for an 80% stenosis."

[4] Respondent's closing brief quotes the letter as follows: "patient is asymptomatic, however, due to the progressive stenosis on the right side, a right CEA was recommended." This quote is inaccurate.

69. As stated in Finding 63, the CDUS reported stenosis of 70 to 80%. To report the stenosis as greater than 80% was therefore inaccurate. The degree of stenosis is a very important factor in determining whether to proceed to surgery, particularly where, as here, a patient is asymptomatic. If his opinion of the degree differed from the radiologist's, he should have written the opinion in the record. Respondent argues that at least in the operative report, his description of the degree of stenosis likely came from his own observations during surgery. But this argument is belied by his statement in his interview, when he said that he could "get a feeling of how much . . . plaque is there. But because you have disrupted it . . . I could not look down the barrel and say . . . it was 80%, because it could look 90% now or . . . 70% now."

70. It was established that Respondent's report of RB's CDUS results was inaccurate, and that this violated the standard of care.

ALLEGATION 2:
Respondent inaccurately reported that RB's carotid duplex showed progressive stenosis of the right carotid artery.

71. Respondent reports four times in the medical record that RB's stenosis in her right carotid was "progressive," but no other evidence supports these statements. Respondent asserts that he based the characterization on his initial performance of a left CEA, and by following her over the subsequent year. Respondent followed up with examinations concerning all of RB's vascular issues, one of which was carotid artery disease. He believed that she had progressive disease in that she had known carotid stenosis and the most recent CDUS had shown narrowing that caused a recommendation for surgery. The left was at less than 40% after surgery, but the right was 70 to 80%, which showed significant disease, sufficient so that she was a candidate for a right CEA. Further, Respondent's consult letter implies that his conclusion that the stenosis increased in the four months between the studies is supported by a comparison of older and newer studies. But there is no older study in the medical record. Dr. Lee's opinion that Respondent's description of the stenosis as progressive was inaccurate and below the standard of care was persuasive.

72. It was established that Respondent's report that RB's CDUS showed "progressive" stenosis was inaccurate, and that this violated the standard of care.

ALLEGATION 3:
Post-operatively, Respondent failed to obtain a completion imaging study in the operating room at the conclusion of the second operation, which is an extreme departure from the standard of care.

73. RB initially did well following the right CEA on January 31, 2011, but as first described above, she was returned to the operating room when she exhibited a neurologic deficit. Immediately prior to and during the second operation, Respondent employed imaging studies and monitoring to assist him that included a CT scan of RB's brain, cerebral monitoring and a series of intraoperative arteriograms. Respondent also utilized his usual method of

continuous wave Doppler, and "look, listen and feel." He did not obtain a completion imaging study at the conclusion of the operation.

74. Drs. Lee and Nathanson again opined that a completion imaging study should have been obtained. They described the intra-operative studies as insufficient to satisfy this requirement. This was not a routine procedure. Respondent performed an end-to-end anastomosis on the artery with a vein graft. An arteriogram revealed a size mismatch between the artery and the vein at the transition point. Given the level of difficulty, the possibility of difficulty with blood flow through the vessel was greater. After the stent was deployed and flow reestablished, a post-intervention angiogram that included all portions of the artery should have been done. Drs. Lee and Nathanson were persuasive that this was an extreme departure.

75. It was established that the failure to do a post-procedure, completion imaging study was an extreme departure from the standard of care and gross negligence.

Patient DC

76. Respondent first saw female patient DC, then 71 years old, on August 18, 2010. She reported having two episodes of slurred speech within a three-week period. Each episode lasted between 10 and 30 minutes. Slurred speech is a symptom of carotid artery disease.

77. There are two reports of imaging studies in the record. A CDUS was taken August 10, 2010, and the radiologist reported "significant calcified atherosclerotic plaque with moderate to moderately severe stenosis of the proximal left internal and proximal left external carotid arteries. Might consider obtaining a CTA of the carotid arteries for further evaluation." An MRA of the carotid arteries and an MRA of the head without contrast were taken on August 13, 2010. The same radiologist reported as her relevant impression, "40 to 50% narrowing of the left carotid bulb with mild narrowing of the proximal left internal carotid artery."

78. In a consult letter dated August 18, 2020, Respondent wrote to the referring physician that the MRA showed "about a 60% left internal carotid artery stenosis and very irregular plaque." He recommended proceeding with a left CEA.

In a history and physical authored by Respondent dated August 20, 2010, he reports that "the MRA was done on August 13, 2010, and this demonstrated . . . a moderate left internal carotid artery stenosis with lots of irregularities of this plaque. The left internal carotid artery is about 60% . . . ."

Respondent performed a left CEA on August 24, 2010. In his operative report, he wrote that testing had showed "stenosis of 60% -70% left internal carotid artery."

79. Complainant alleges that Respondent's care of DC constituted gross negligence, negligence and/or incompetence and/or the failure to maintain adequate and accurate records in the following three respects.

ALLEGATION 1:
Respondent's performance of [CEA] on DC . . . was not indicated given the CDUS and MRA findings, which Respondent incorrectly reported as "about 60%" stenosis.

80. The standard of care for the performance of a CEA in most symptomatic patients is a finding of stenosis of greater than 50%. Here, an inconclusive CDUS was followed by an MRA showing "40 to 50% narrowing of the left carotid bulb with mild narrowing of the proximal left internal carotid artery." MRA's are known to overcall the degree of stenosis, and yet Respondent documented and told others that DC had "about 60%" stenosis in her left carotid artery, and performed a CEA. Drs. Lee and Nathanson reviewed the imaging studies, and found no basis for a conclusion of 60%. If there was truly a concern that the stenosis was greater than 50%, a conventional angiogram (which is invasive, but less so than a CEA procedure) should have been performed. They opined that DC should have been managed medically, and that the performance of the CEA was an extreme departure from the standard of care.

81. Respondent testified that he, too, reviewed the imaging studies themselves, and prior to the surgery. In addition, he asserts that he had extensive discussions with other physicians and that a treatment plan was devised to treat the left internal carotid artery stenosis prior to treating a cerebral artery lesion. In his Board interview, however, he only said that he reviewed the reports from the radiologist. And there is no documentation of the reason for the 60% conclusion or of this more global treatment plan in the medical record. The opinions of Drs. Schwartz, Milner, and Shoor appear to be based at least in part on what Respondent explained to them, and not as much on the medical record, which lessened the value of the opinions. The standard of care requires that a decision to proceed with a CEA must be made following a clear medical indication for the procedure, and the evidence did not establish such in this case.

82. It was established that the performance of a CEA on DC was an extreme departure from the standard of care and gross negligence.

ALLEGATION 2:
Respondent's documentation of stenosis of "about 60%" without explanation for the basis for his disregard of the radiologist's MRA findings constitutes unprofessional conduct.

83. As previously stated, the degree of stenosis is a crucial fact in determining whether a CEA should be performed. Performance of a CEA requires a clear medical indication and documentation of the indication in the medical record. It was established that the standard of care required Respondent to explain why he concluded that the degree of stenosis was so much greater than stated in the radiology reports so that the record revealed a clear medical indication for performance of the CEA.

84. It was established that Respondent's failure to explain his disregard of the radiologist's findings as regards DC was a departure from the standard of care.

ALLEGATION 3:
Respondent's reporting in his clinical notes and in his correspondence that the August 13, 2010 MRA showed that DC had "about 60%" stenosis was false and/or misleading, and/or a failure to maintain adequate and accurate records, and/or false representations in the medical records.

85. As concluded above, it was established that Respondent's reporting of "about 60%" stenosis in the matter of DC was negligent, and hence unprofessional conduct. It also represented a failure to maintain medical records as required by the standard of care for documentation.

A finding that the negligent act was also false and misleading would imply an element of willful conduct. It was not established to the required standard that Respondent's representations in this regard were deliberately incorrect.

86. It was established that Respondent failed maintain adequate and accurate patient medical records for DC.

Patient SD

87. Patient SD, then a 74-year-old female, was reported by Respondent in a preoperative history and physical as suffering from "some near syncopal events." On one of these occasions, December 2, 2009, she fell and struck her head. She underwent a CAT scan that showed a left frontal hematoma. On December 8, a CDUS was performed and the radiologist reported 26 to 54% stenosis in the right internal carotid artery and 65 to 66% stenosis in the right carotid bulb. The velocity was within normal range. No stenosis percentage was reported for the left internal carotid artery. As regards the left carotid bulb, the radiologist reported "mild plaque formation."

88. On January 8, 2010, Respondent performed a right CEA on SD. In his preoperative history and physical of the same date, he reported that SD's December 8 CDUS "showed mild left internal carotid artery stenosis but rather severe right internal carotid artery stenosis of about 80%." In his operative report, Respondent reported that the CDUS "demonstrated severe stenosis in the right internal carotid artery. However, irregular plaque may be as tight as 80%."

89. Complainant alleges that Respondent's care of SD constituted gross negligence, negligence and/or incompetence and/or the failure to maintain adequate and accurate records in the following four respects.

ALLEGATION 1:
Respondent's performance of a right CEA on SD was not indicated given that SD was asymptomatic and had normal carotid artery velocities. Based on the CDUS report, SD had minimal stenosis of 26-54% of the right internal carotid artery.

90. Respondent believed that SD's syncope episodes of feeling light-headed and passing out made her symptomatic and that she was at risk for stroke. Syncope can have many causes. It is properly considered when making a differential diagnosis, but it is not a symptom of carotid artery disease according to Rutherford's, other medical literature, and Drs. Lee and Nathanson. As the evidence established that syncope is not a symptom of carotid artery disease, SD is properly evaluated as an asymptomatic patient.

91. A CEA may be indicated for asymptomatic patients with a minimum of 60% stenosis. The imaging studies showed 26 to 54% stenosis in the right internal, but the finding was 65-66% in the right carotid bulb. These results are far below 80%, but are sufficiently high to consider a right CEA.

92. Dr. Lee's opinion that the right artery was "normal" is not substantiated by the record. Dr. Nathanson opined that there was disease in SD's right carotid, but he would have obtained another imaging study as well as a workup on the reported syncope and would not have operated based on the CDUS alone. Dr. Nathanson found a simple departure because the patient did have some degree of disease on the right side, but a workup of the syncope was not done.

93. It was not established to the required standard that Respondent's performance of the CEA was a departure from the standard of care.

ALLEGATION 2:
Respondent's reporting in the medical records that the December 8, 2009, CDUS showed that SD had "severe stenosis" and "about 80%" stenosis of the right carotid artery was false and/or misleading, and/or an inaccurate medical record, and/or false representation.

94. Respondent testified that he interpreted the CDUS report as finding that SD had severe stenosis in her right carotid artery. Asked about writing 80% in his pre-op report, he said that "the number might have been biased by what I saw at the time of surgery," which of course was after the fact and could not be used to justify its inclusion in the pre-op report.

95. The CDUS does contain a conclusion of "severe stenosis," but this reference is insufficient support for Respondent's report of "about 80%" stenosis. Dr. Nathanson found no support for Respondent's report of 80% stenosis, and characterized it as a completely false statement.

96. Respondent's report of SD's stenosis as "about 80%" in his preoperative report was inaccurate. It represented a failure to maintain medical records as required by the standard of care for documentation. A finding that the act was also false and/or misleading would imply an element of willful conduct. It was not established to the required standard that Respondent's representations in this regard were deliberately incorrect.

97. It was established that Respondent failed to maintain accurate adequate and accurate patient records for SD.

ALLEGATION 3:
Respondent's documentation of stenosis of "about 80%" without explanation for his disregard for the radiologist's ultrasound findings constituted gross negligence and/or negligence.

98. As previously found, the degree of stenosis is a crucial fact in determining whether a CEA should be performed. Performance of a CEA requires a clear medical indication and documentation of the indication in the medical record. The standard of care required Respondent to explain why he concluded that the degree of stenosis was so much greater than stated in the radiology reports so that the record revealed a clear medical indication for performance of the CEA.

99. It was established that Respondent's failure to document an explanation for his reporting of stenosis of "about 80%" was below the standard of care and negligent.

ALLEGATION 4:
Respondent's classification of SD as being symptomatic, in that he attributed her near syncopal events to carotid artery stenosis without a full workup or evaluation of the events constituted gross negligence, negligence, and/or incompetence.

100. Respondent's medical record concerning SD contains the inaccurate statement that syncope is symptomatic of carotid artery disease. He also reported in his interview and testified that this is his belief. Respondent's belief is at odds with the other experts and the medical literature. In addition, Respondent failed to obtain a full workup or evaluation of SD's syncopal events.

101. It was established that Respondent's classification of SD as symptomatic due to syncope without first evaluating the syncope was a simple departure from the standard of care and negligent. It also demonstrated incompetence.

Patient BL

102. On October 7, 2010, Respondent saw BL, then a male age 91, for an evaluation of left internal carotid artery stenosis. He lived independently and was quite physically active. An echocardiogram was taken in 2007, confirming BL had atrial fibrillation. He complained of intermittent syncopal episodes for one to two years. A CDUS taken July 2, 2010, revealed 10% narrowing of the proximal right internal carotid artery and 60% of the left.

Respondent wrote to one of BL's physicians that the CDUS showed "an irregular 60 to 69% stenosis." He also wrote

> [BL] is neurologically intact. He does describe though syncopal episodes whenever he lifts his left arm over his head. He has a strong radial pulse and no blood pressure discrepancy between the left and right arm and I cannot elicit any vertebral steal syndrome, but he states that this has happened six or seven times this year and with the known carotid artery stenosis, I am recommending that he undergo a carotid endarterectomy.

103. BL chose to have a CEA. In his preoperative history and physical, Respondent reported that the July CDUS showed "50% to 69% left internal carotid artery stenosis. With this being a borderline stenosis, he was followed but since the symptoms are so dramatic and so consistent he was then referred for vascular surgical evaluation and recommended for admission and surgery at this time."

104. Respondent performed a left CEA on October 29, 2010. He noted the same preoperative and postoperative diagnoses: "Symptomatic left internal carotid artery stenosis." The procedure went well and BL was discharged on October 31, 2010.

105. Complainant alleges that Respondent's care of BL constituted gross negligence, negligence and/or incompetence and the failure to maintain adequate and accurate records in the following four respects.

ALLEGATION 1:
Respondent inaccurately and inconsistently reported Patient BL's carotid duplex results, which constitutes inadequate and inaccurate medical records.

106. There was one imaging study on BL, and that stated his degree of stenosis as 60%. Respondent's report of "50 to 69%" and "60 to 69%" were inaccurate statements. No explanation of the difference between his report and the radiologist's was given.

107. It was established that Respondent failed to maintain adequate and accurate medical records regarding BL.

ALLEGATION 2:
Respondent's performance of a carotid endarterectomy on patient BL was not indicated given that he was 91 years old, had medical comorbidities, had moderate carotid artery stenosis, and was asymptomatic.

108. Dr. Lee opined that it was an extreme departure for Respondent to perform a CEA on BL for the following reasons: he was asymptomatic, as syncope is not a qualifying symptom; the degree of stenosis was not high enough (he testified that the CDUS showed 50% to 69%); he had atrial fibrillation and "a few other morbid conditions"; and he was 91 years old. Dr. Lee opined that "a reasonable physician would have recommended medical management."

109. It was not established that chronological age is a valid reason for not performing a CEA. The standard of care requires the elderly to be evaluated as individuals.

110. It was not established that BL suffered from "multiple comorbidities." The only documented comorbidity was the atrial fibrillation, which was controlled.

111. Dr. Nathanson would "generously describe [Respondent's] approach as unconventional" and specified the type of information he would need prior to performing a CEA. He credited Respondent for discussing BL's cardiac history, but a workup to rule out cardiac issues as a possible source of the syncope should have been performed, instead of proceeding first to "go after the mild stenosis." Dr. Nathanson pointed out that it is "unusual for cerebrovascular disease in the form of an isolated carotid stenosis to be responsible for a syncopal event." He opined that it is not a departure from the standard of care to operate on a 91-year-old, but it is inaccurate to describe BL as symptomatic, and it was below the standard to proceed with a CEA with this amount of information.

112. Respondent noted that BL had been under the care of two other physicians for a long time. He had a heart monitor for his atrial fibrillation and was "fully functioning." He chopped wood, drove a car, and was a good candidate for surgery if it were indicated. His doctors had referred him to Respondent following workups that showed no other reason for the syncopal episodes, following a CDUS that showed 60% stenosis.

113. Dr. Shoor concurred that regardless of the relationship of the syncope to the stenosis, 60% met the criteria for a CEA, and given the velocity measurements, he read the study as showing 65% stenosis. BL's cardiologist and internist were perplexed by the syncope and although it is not a common symptom of carotid artery disease, they sent him for a CDUS. Dr. Shoor opined that BL was not symptomatic, but that he nonetheless was a candidate for a CEA.

114. Dr. Milner opined that Respondent's performance of the CEA was within the standard of care. He opined that BL's syncopal episodes made him symptomatic. But even if he were not, there was sufficient stenosis reported to support a CEA.

115. Dr. Schwartz agreed that ongoing medical evaluation was indicated and that the CEA might have been indicated. He saw no evidence of lack of knowledge and the affirmative evidence of successful therapy accomplished. Medical and cardiology clearances were obtained, which is appropriate for elderly patients. It was reasonable for Respondent to rely on their recommendation that he could undergo the CEA.

116. It was not established to the required legal standard that the performance of a CEA on BL was below the standard of care.

ALLEGATION 3:
Respondent's classification of BL as symptomatic was below the standard of care.

117. Respondent wrote that BL's syncope "has happened six or seven times this year and with the known carotid artery stenosis, I am recommending that he undergo a [CEA]." Respondent has consistently stated that syncope is a symptom of carotid artery disease, and the evidence established that it is not.

118. The evidence established that Respondent's classification of BL as symptomatic was a departure from the standard of care and negligent. It was also incompetent.

ALLEGATION 4:
Respondent's attribution of BL's syncopal events to carotid artery stenosis without obtaining a full workup or evaluation of his syncopal events was below the standard of care.

119. Syncope is not a symptom of carotid artery disease; it does not indicate the presence of that disease and can be caused by multiple physical conditions. By his writing and his oral statements that syncope is such a symptom, it is reasonably inferred that Respondent attributed BL's syncopal events to carotid artery stenosis. Dr. Nathanson was persuasive that BL's syncope should have been subjected to a differential diagnosis analysis prior to the performance of a CEA.

120. It was established that Respondent's failure to fully evaluate BL's syncopal events was below the standard of care and negligence.

Other evidence

121. Keith Korver, M.D., is board certified as a general surgeon and as a cardiac thoracic surgeon. He has been licensed as a physician in California since 1982. Dr. Korver is on the staff of 15 hospitals in the Bay Area, although he is predominantly associated with Sutter Santa Rosa, where he started the heart surgery program.

122. Dr. Korver first met Respondent when they were enrolled in residency programs at UCSF. Respondent moved to Michigan to practice, and they became reacquainted when Respondent returned to California to complete a fellowship at Stanford. Dr. Korver was with Northern California Medical Associates (NCMA) in Santa Rosa, a group of approximately 40 physicians. He had a hand in helping to recruit Respondent, and was very pleased when he joined NCMA. With Respondent, NCMA was able to increase carotid artery operations from two to three per year to 70 to 80. As a result, a whole new class of patients could be cared for and new techniques were employed at Sutter Santa Rosa.

123. Respondent started NCMA's vascular surgery program, and Dr. Korver assisted him frequently in the beginning as he wanted him to succeed. He noted that Respondent took on long and difficult cases, such as procedures to save the feet of diabetics, which last five or six hours. They worked together for five to six years, and split call duties 50-50, which he notes was a bit unfair because he is not a vascular surgeon.

Dr. Korver opined that Respondent is an excellent technical surgeon and that his judgment in cardiac surgery is excellent. He based his opinion on the many hours they worked together, assisting each other. Dr. Korver believes that of the approximately 50 surgeons he has observed perform carotid artery procedures, Respondent is in the top two or three; "he is superb."

124. Dr. Korver also opined regarding Respondent's personal interactions with patients. He described him as an excellent person and a great partner, who talks easily with others and is very empathetic with patients. Respondent takes constructive criticism, and they talked about failings and successes in their practices. Dr. Korver believes that Respondent exhibited insight and would engage in self-improvement.

125. Mohammad Hossein Mir-Sepasi, M.D., is board certified as a surgeon and a cardiothoracic surgeon. He obtained his medical degree from Johns Hopkins, then returned to his native Iran to practice. Following the Iranian revolution, he immigrated to the United States, practicing first in Virginia. He moved to California in 1999 and joined a group practice. After approximately two years, Dr. Korver approached him regarding working as an assistant in surgical procedures, and Dr. Mir-Sepasi joined NCMA. He assisted Dr. Korver, Respondent, and another surgeon, and also assisted with the after care of surgical patients. He is now retired.

Dr. Mir-Sepasi has known Respondent since 2007, when Respondent joined NCMA. He has assisted Respondent in numerous surgeries. Dr. Mir-Sepasi described Respondent as a "very good technical surgeon in vascular surgery." He has shown good clinical judgment in the operating room and interacts well with other members of the surgical team.

LEGAL CONCLUSIONS

1. Unprofessional conduct is grounds for discipline of a physician's certificate pursuant to Business and Professions Code section 2234. Unprofessional conduct includes gross negligence (Bus. & Prof. Code, § 2234, subd. (b)), repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)), incompetence (Bus. & Prof. Code, § 2234, subd. (d)), and the failure to maintain adequate and accurate patient records (Bus. & Prof. Code, § 2266).

2. The evidence established that Respondent was grossly negligent in the treatment of patients SB, RB, and DC. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (b), by reason of the matters set forth in Findings 54 through 59, 73 through 75 and 80 through 82.

3. The evidence established that Respondent committed repeated negligent acts, in that simple departures from the standard of care were found in his treatment of all five patients. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (c), by reason of the matters set forth in Findings 50 through 53, 68 through 72, 83, 84, 98 through 101, and 117 through 120.

4. In the context of professional licensing, "incompetence" means "a lack of knowledge or ability in the discharging of professional obligations. Often, incompetence results from a correctable fault or defect." (*James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109.) The evidence established that Respondent lacked competence in his treatment of SD and BL. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (d), by reason of the matters set forth in Findings 100, 101, 117 and 118..

5. The evidence established that Respondent failed to maintain adequate and accurate patent records as regards patients SB, DC, SD, and BL. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2266, by reason of the matters set forth in Findings 60, 61, 85, 86, 94 through 97, 106, and 107.

6. As cause for discipline has been established, it remains to determine the appropriate level of discipline to impose. In making this determination, it is recognized that the purpose of these proceedings is to protect the public, not to punish physicians. Depending upon the violations, the goal is to remediate physicians whenever possible.

Before the Board is an experienced and talented vascular surgeon whose care of five patients was below the standard of care in different respects. Other than as needed for hearing scheduling purposes and to describe his career history, the timing of the care of the patients vis-à-vis the tremendous strain and tragedy of Respondent's son's cancer was not discussed. But it is striking that this enormous personal problem was ongoing over roughly the same time period as Respondent's care of the five patients in this case. Although this does not excuse or even mitigate the violations, it does supply important context. It is also noted that Complainant recommends license probation.

It is concluded that the public interest will be served and protected, and that Respondent's practice will be assisted, by a five-year term of probation pursuant to the conditions set forth below.

ORDER

Physician's and Surgeon's Certificate No. A44147, issued to Respondent James E. O'Dorisio, M.D., is revoked; however, revocation is stayed and Respondent is placed on probation for five years under the following terms and conditions.

1. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine (Program). Respondent shall successfully complete the Program not later than six months

after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. Determination as to whether Respondent successfully completed the examination or successfully completed the program is solely within Program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program has been completed. If Respondent did not successfully complete the clinical training program, Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

2. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent

shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

3. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

4. Monitoring - Practice

Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name, and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual

practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

5. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, Respondent's practice setting changes and Respondent is no longer practicing in a setting in compliance with this Decision, Respondent shall notify the Board or its designee within five calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

6. Notification

Within seven days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities, or insurance carrier.

7. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

8. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

11. Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

12. Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

13. License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's certificate.

14. Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

15. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

16. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws and General Probation Requirements.

17. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

DATED: July 22, 2015

MARY-MARGARET ANDERSON
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: **JAMES E. O'DORISIO, M.D.** 3536 Mendocino Ave., #200 Santa Rosa, CA 95403 Physician's and Surgeon's Certificate No. A44147 Respondent.	Case No. 12-2011-217415 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Second Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about October 26, 1987, the Medical Board of California issued Physician's and Surgeon's Certificate No. A44147 to James E. O'Dorisio, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2015, unless renewed.

JURISDICTION

3. This Second Amended Accusation is brought before the Medical Board of California (Board), [1] Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states in relevant part:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board."

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

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[1] The term "Board" means the Medical Board of California; "Division of Medical Quality" shall also be deemed to refer to the Board.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon."

7. Section 2261 of the Code, states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine ... which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

8. Section 2266 of the Code, states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence and/or Negligence and/or Incompetence and/or Failure to Maintain Adequate and Accurate Records re Patient S.B. [2])

9. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2234, including subsections (b) and/or (c) and/or (d) and/or under Code section 2266, in

[2] Patient names have been abbreviated to protect their privacy.

that Respondent was grossly negligent and/or negligent and/or incompetent in his care and treatment of Patient S.B., and/or failed to maintain adequate and accurate medical records. The circumstances are as follows:

10. On March 4, 2010, S.B., an 80-year old male patient, saw Respondent for a vascular surgery consultation. Respondent noted that S.B. had a history of a previous stroke and left carotid endarterectomy eight years ago. Respondent reviewed a carotid artery duplex ultrasound done on February 11, 2010 and noted that it had demonstrated a 90% left internal carotid artery stenosis, with peak velocities over 600 cm/sec. S.B. denied having any TIA (transient ischemic attack) symptoms, syncope, or new weaknesses. Respondent did not obtain additional imaging studies. Respondent noted that the option of carotid stenting was discussed with S.B. but that S.B. was not interested in stenting and wanted instead to proceed with elective carotid surgery.

11. On March 19, 2010, Respondent attempted to perform a redo left carotid endarterectomy on S.B. According to Respondent's operative report, the surgery was long and difficult, and "a classic endarterectomy was not done" due to hyperplasia throughout the carotid artery. The operative report identifies the operation performed as "redo common carotid patch angioplasty with extension to internal carotid under shunt protection." Respondent's records do not document a completion imaging study in the operating room. Respondent's records do not document the presence of a surgical assistant during the procedure.

12. Within approximately one hour after the completion of surgery, at about 11:30 p.m., Respondent documented that S.B. had right arm weakness, could not follow commands and could not speak, indicating profound neurological deficit. Respondent failed to create or document a treatment plan.

13. A carotid artery ultrasound was not ordered until the next morning at approximately 4:35 a.m. That study demonstrated an occluded left carotid artery.

14. S.B. died on March 23, 2010 of massive stroke. Respondent did not dictate the operative report until April 7, 2010.

15. Respondent's overall conduct, acts, and/or omissions, with regard to patient S.B., constitutes unprofessional conduct through gross negligence and/or negligence and/or

incompetence, and/or failure to maintain adequate and accurate records. More specifically, Respondent is guilty of unprofessional conduct with regard to S.B. as follows:

a. Preoperatively, Respondent did not obtain appropriate imaging studies, such as a CT angiogram, and did not provide proper counseling to S.B. prior to surgery.

b. Intraoperatively, Respondent failed to obtain and/or document a completion imaging study in the operating room at the conclusion of the operation.

c. Post-operatively, when it was observed that S.B. had neurologic deficits, Respondent failed to properly evaluate, diagnose or exclude a technical problem. The standard of care is to manage the problem immediately, with either urgent carotid duplex study or re-exploration of the carotid artery. Neither was done.

d. Respondent's failure to dictate his operative report in a timely manner, his failure to document the presence of an assistant during the procedure, his failure to document a completion study (if one was done), and his failure to document a treatment plan when neurological deficits were observed constitutes unprofessional conduct and the failure to maintain adequate and accurate medical records is cause for discipline pursuant to section 2266 of the Code.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence and/or Negligence and/or Incompetence and/or Dishonest Acts and/or Failure to Maintain Adequate and Accurate Records, and/or False Representations re Patient R.B.)

16. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2234, including subsections (b) and/or (c) and/or (d) and/or (e) and /or under Code section 2266 and 2261, in that Respondent was grossly negligent and/or negligent and/or incompetent in his care and treatment of Patient R.B., and/or failed to maintain adequate and accurate medical records, and/or made false representations in the medical records. The circumstances are as follows:

17. On August 13, 2010, Respondent performed a left carotid endarterectomy on R.B., a then 66-year old female patient. On October 5, 2010, Respondent performed an abdominal aorta and bilateral common iliac balloon angioplasty on R.B.

18. On December 16, 2010, R.B. saw Respondent for a follow-up examination. Respondent noted that a carotid ultrasound showed progressive stenosis of the right carotid artery "approaching 80%." Respondent also noted that R.B. was asymptomatic, but because of progressive stenosis on the right side, elective right carotid endarterectomy was discussed and planned for January of 2011.

19. On January 31, 2011, Respondent noted that Patient R.B. was brought in for an elective right carotid endarterectomy for a "greater than 80% right internal carotid artery stenosis." However, Patient R.B.'s December 10, 2010 carotid duplex revealed a stenosis of 70-80% of the right internal carotid artery.

20. On January 31, 2011, Respondent performed a right carotid endarterectomy on R.B. Post-operatively, R.B. developed neurologic deficit. A carotid duplex was obtained and showed compromised flow through the internal carotid artery. R.B. was returned to the operating room for emergency re-exploration. According to Respondent's operative report, R.B.'s artery was "friable" and difficult to repair. Respondent then used a saphenous vein from the left ankle to replace a segment of the artery and placed a self-expanding stent in the internal carotid artery. At the conclusion of the surgery, Respondent did not obtain and/or document a completion imaging study.

21. On February 2, 2011, R.B. died of a stroke.

22. Respondent's overall conduct, acts, and/or omissions, with regard to patient R.B., constitutes unprofessional conduct through gross negligence and/or negligence and/or incompetence, and/or the failure to keep adequate and accurate medical records, and/or the making of false representations in the medical records. More specifically, Respondent is guilty of unprofessional conduct with regard to R.B. as follows:

a. Respondent inaccurately and inconsistently reported Patient R.B.'s carotid duplex results, including the degree of stenosis.

b. Respondent inaccurately reported that R.B.'s carotid duplex showed progressive stenosis of the right carotid artery.

c. Post-operatively, Respondent failed to obtain a completion imaging study in the operating room at the conclusion of the second operation, which is an extreme departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence, and/or Negligence, and/or Incompetence, Unprofessional Conduct, Dishonest Acts and/or Failure to Maintain Adequate and Accurate Records, and/or False Representations re Patient D.C.)

23. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2234, including subsections (b) and/or (c), and/or (d), and/or (e), and /or under Code section 2266, and/or Code section 2261, in that Respondent was grossly negligent and/or negligent and/or incompetent in his care and treatment of Patient D.C., and/or failed to maintain adequate and accurate medical records, and/or made false representations in the medical records. The circumstances are as follows:

24. On August 18, 2010, Respondent saw patient D.C., a then 71-year old female patient who reported having two episodes of slurred speech lasting several minutes. In his clinical notes, Respondent reported that D.C. had undergone a carotid duplex and also an MRA (magnetic resonance angiography), and he noted that the MRA had demonstrated a "moderate left internal carotid artery stenoses . . . about 60%."

25. The carotid duplex report dated August 10, 2010, showed peak systolic velocity for the left ICA (internal carotid artery) was 158 cm/sec and end diastolic velocity for the left ICA was 43 cm/sec. The radiologist recommended a further imaging study because the ultrasound was inconclusive.

26. The MRA radiology report dated August 13, 2010, however, showed only "40 to 50% narrowing of the left carotid bulb... but only mild narrowing of the proximal left internal carotid artery."

27. On August 24, 2010, Respondent performed elective left carotid endarterectomy on D.C.

28. Respondent's performance of carotid endarterectomy on D.C. constitutes unprofessional conduct through gross negligence, negligence, and/or incompetence in that the procedure was not indicated given the carotid duplex and MRA findings, which Respondent incorrectly reported as "about 60%" stenosis.

29. Respondent's documentation of stenosis of "about 60%" without explanation for the basis for his disregard of the radiologist's MRA findings constitutes unprofessional conduct through gross negligence, negligence, and/or incompetence.

30. Respondent's reporting in his clinical notes and in his correspondence that the August 13, 2010 MRA showed that D.C. had "about 60%" stenosis was false and/or misleading, and/or a failure to maintain adequate and accurate records, and/or false representations in the medical records, and constitutes unprofessional conduct and cause for discipline pursuant to sections 2234 (b) and/or (c) and/or (d) and/or (e), 2261, and 2266 of the Code.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence, Negligence, and/or Incompetence and/or Unprofessional Conduct, Dishonest Acts, and/or Failure to Maintain Adequate and Accurate Records, and/or False Representations re Patient S.D.)

31. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2234, including subsections (b) and/or (c) and/or (d), and/or (e) and/or Code section 2266, and/or Code section 2261, in that Respondent was grossly negligent, negligent, and/or incompetent, in his care and treatment of Patient S.D., and/or failed to maintain adequate and accurate medical records, and/or made false representations in the medical records. The circumstances are as follows:

32. In or about December 2009, patient S.D., a then 74-year old female patient, reported having "near syncopal events," including an event that caused her to fall on December 2, 2009.

33. On December 8, 2009, a carotid ultrasound was performed, and showed right carotid artery velocities of 54/19 cm/sec and an ICA:CCA ratio of 1:794. The radiologist's findings were 26-54% stenosis in the right internal carotid artery and 65-66% stenosis in the right carotid bulb;

however, turbulence was not observed. Based on the lab's reported criteria, the velocity was within normal range.

34. Respondent reported in his pre-operative report that the December 8, 2009 carotid ultrasound showed "severe right internal carotid artery stenosis of about 80%."

35. Respondent falsely and/or inaccurately reported in his pre-operative report that the December 8, 2009 ultrasound showed "bilateral carotid stenosis of 60-70% left internal carotid artery."

36. On March 8, 2010, Respondent performed a right carotid endarterectomy on S.D.

37. Respondent's performance of carotid endarterectomy on patient S.D. constitutes unprofessional conduct through gross negligence, negligence, and/or incompetence in that the procedure was not indicated given that patient S.D. was asymptomatic and had normal carotid artery velocities. Based on the ultrasound report, Patient S.D. had minimal stenosis of 26-54% of the right internal carotid artery.

38. Respondent's reporting in the medical records that the December 8, 2009 carotid ultrasound showed that S.D had "severe stenosis" and "about 80%" stenosis of the right internal carotid artery was false and/or misleading, and/or an inadequate and inaccurate medical record, and/or false representation, and constitutes unprofessional conduct and cause for discipline pursuant to sections 2234 (b) and/or (c) and/or (d) and/or (e), and/or 2261, and/or 2266 of the Code.

39. Respondent's documentation of stenosis of "about 80%" without explanation for the basis for his disregard of the radiologist's ultrasound findings constitutes unprofessional conduct through gross negligence and/or negligence.

40. Respondent's classification of Patient S.D. as being symptomatic constitutes gross negligence, negligence and/or incompetence. Attributing her near syncopal events to carotid artery stenosis without obtaining a full workup or evaluation of her syncopal events constitutes gross negligence, negligence, and/or incompetence.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence, Negligence, and/or Incompetence, and/or Unprofessional Conduct, Dishonest Acts, and/or Failure to Maintain Adequate and Accurate Records re Patient B.L.)

41. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2234, including subsections (b) and/or (c), and/or (d), and/or (e) and/or Code section 2266 in that Respondent was grossly negligent, negligent, and/or incompetent in his care and treatment of Patient B.L. and/or failed to maintain adequate and accurate medical records. The circumstances are as follows:

42. On October 7, 2010, B.L., a then 90-year male patient, was seen by Respondent for evaluation of left internal carotid artery stenosis. B.L. reported having syncopal episodes when lifting his left arm over his head. Respondent noted in correspondence that a carotid ultrasound performed on July 2, 2010 showed an "irregular 60-69% stenosis of the left internal carotid artery." Noting B.L.'s syncopal episodes and carotid artery stenosis, Respondent recommended elective carotid endarterectomy.

43. Respondent noted in B.L.'s pre-operative report that the July 2010 ultrasound showed a "50-69% left internal carotid artery stenosis. With this being a borderline stenosis he was followed, but since the symptoms are so dramatic and so consistent he was then referred for vascular surgery evaluation and recommended for admission and surgery at this time."

44. The July 2, 2010 carotid artery ultrasound demonstrated left carotid artery velocities of 180/41 cm/sec and an ICA:CCA ratio of 2:9. The radiologist's conclusion was "60% narrowing of the proximal left internal carotid artery."

45. Respondent inaccurately and inconsistently reported Patient B.L.'s carotid duplex results, which constitutes inadequate and inaccurate medical records and cause for discipline pursuant to section 2266 of the Code.

46. On October 29, 2010, Respondent performed a left carotid endarterectomy on B.L.

47. Respondent's performance of a carotid endarterectomy on patient B.L. constitutes unprofessional conduct through gross negligence, negligence, and/or incompetence in that the

procedure was not indicated given that patient B.L. was 91 years old, had medical comorbidities, had moderate carotid artery stenosis, and was asymptomatic.

48. Respondent's classification of Patient B.L. as being symptomatic constitutes gross negligence, negligence and/or incompetence. Attributing his syncopal events to carotid artery stenosis without obtaining a full workup or evaluation of his syncopal events constitutes gross negligence, negligence, and/or incompetence.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A44147, issued to James E. O'Dorisio, M.D;

2. Revoking, suspending or denying approval of James E. O'Dorisio, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering James E. O'Dorisio, M.D., if placed on probation, to pay the Medical Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: February 24, 2015

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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